Tennessee Department of Labor and Workforce Development
Division of Workers' Compensation

Consultation Services on Workers' Compensation Laws, Processes, and Costs
RFP 33703-02712

Consultants' Final Report
August 28, 2012

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STRATEGIES

List of Abbreviations

ACOEM - American College of Occupational and Environmental Medicine

AMA – American Medical Association

ASC – Ambulatory Surgical Center

AWW – Average Weekly Wage

BRC – Benefit Review Conference

CPT – Current Procedural Terminology

DFWP – Drug-Free Workplace Program

DOL – Tennessee Department of Labor

MMI – Maximum Medical Improvement

NCCI – National Council on Compensation Insurance

ODG – Official Disability Guidelines

PPD – Permanent Partial Disability

RBRVS – Resource Based Relative Value System

RFA – Request for Assistance

TTD – Temporary Total Disability

UR – Utilization Review

WCRI – Workers Compensation Research Institute

Executive Summary

The Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation (referred to here as the Division), issued a Request for Proposals (June 2012) for consulting services to review Tennessee's workers' compensation system "to determine whether there are changes to laws, rules, processes, and/or administrative structure that would improve the state's workers' compensation system and improve outcomes for both employees and employers." This is the final report of that review. The goals and methods of the study and highlights of the findings are summarized in this section. The full report contains the detailed recommendations and supporting information.

Since 1986, Tennessee's workers' compensation costs, as measured by insurance rates, experienced periods of growth and decline. Overall insurance rates are currently slightly above 1986 levels. Since 2004, premium rates have declined in Tennessee and its neighboring states, but Tennessee's relative ranking among neighboring states is higher. There is evidence that in some areas, Tennessee's costs outpace its neighbors. This is particularly true with certain medical fees, hospital costs and permanent injury indemnity. There is also evidence that case outcomes of injured workers are worsening. This is true in cases of injuries that result in permanent impairment, where durations are lengthening.

There is also evidence that Tennessee's employers and employees are experiencing unnecessary difficulty in navigating the workers' compensation system. Some of this difficulty is caused by unnecessary complexity both in the law and its administration. Another cause is the inherent difficulty of knowing what to do when you have a workers' compensation claim. Confusion and misinformation about handling a claim and delays in medical care and benefit payments will inevitably lead to unnecessary time away from work and higher claims cost. The Division has made progress in increasing education and outreach efforts to address such issues, but as discussed later in this report, more efforts are called for.

In this report, we provide recommendations that not only address the "hot button" issues in the forefront of stakeholder concerns, but also make fundamental improvements to the system that will avoid having to "reform" it again every few years.[1] Some important principles that guided our vision for these fundamental improvements are:

- Simplify and clarify overly complex systems.

[1] The last major reform of Tennessee's workers' compensation system occurred in 2004, when several changes were made, including instituting a fee schedule and mandating certain administrative dispute resolution procedures before trial. Since then, additional changes have taken place. Most recently, in

- Provide strong incentives for desirable behavior and disincentives for counter-productive behavior throughout the claim process.
- Model best practices of other states.
- Strive to make the system as "self-executing" as possible.

Briefly summarized here are the highlights of the recommendations. Details on all recommendations are in the main body of the report. Singled out in this summary are those recommendations with the greatest system impact. Recommendations are grouped under three headings, related to laws and benefits, medicine, and administration.

The dozens of recommendations contained herein should be viewed as a whole. They are interrelated and in many cases work together to attain the above guiding principles. On balance, we believe that the recommendations present gains for employers, employees, and providers. The primary gains for employers are cost reduction, predictability, and more efficient claims handling processes. The primary gains for employees are fewer delays, better medical treatment, claim processes that are easier to follow and support from the Division when problems arise. The primary gains for medical providers relate to fewer challenges to treatment plans, less burdensome paperwork, and roles in the system that are well explained and supportive. Taken together, the recommendations present a model for Tennessee to have a more self-executing, more predictable, fairer, and more efficient workers' compensation system for all stakeholders.

Law and Benefits

Recommendations here seek to shift the standards by which compensable claims are determined and to provide a fair and efficient administrative system for applying the law to disputes; indemnity benefits are addressed with a variety of changes.

- We recommend incremental changes to clarify and narrow the definition of causation. Also in this regard, we recommend a "neutral" standard for judges in applying the workers' compensation law to disputed cases.
- We recommend shifting adjudication of disputed claims from the courts to a purely administrative process. This will involve major restructure of the Division.
- We recommend a few incremental changes to TTD benefits, and substantial restructuring of PPD benefits.

Medical

These recommendations address the high and escalating cost of treating injured workers, and also other processes that affect the delivery of high quality medical care to injured workers.

- We recommend major changes to the Tennessee fee schedule that will provide better incentives for the treatment of work injuries, while achieving some further cost reductions from institutional providers.
- We recommend a number of new requirements to focus utilization review on true treatment problems, and to expedite disputes over treatment.
- We recommend many specific changes in how employers select panels so as to avoid confusion and delay for injured workers.
- We recommend an alternative method to select physicians to do impairment ratings.
- Finally, we have recommendations to institute electronic medical billing and speed up the payment for services provided to injured workers.

Together, these improvements will help speed up the delivery of medical care to injured workers, remove unnecessary and inefficient processes, and reduce administrative costs to medical providers and benefit costs to employers. These are improvements that should revitalize interest among doctors in practicing occupational medicine.

Administrative

In keeping with our charge to conduct a comprehensive review of the entire workers' compensation system, we have made recommendations on the following administrative features of the system.

- We examined the option for employers to voluntarily withdraw from the workers' compensation system but recommend against this option until specific problems can be resolved.
- We recommend a broad range of administrative actions to assist injured workers with their questions and claims; foremost of these is the creation of an Ombudsman program.
- We recommend a narrow extension of the drug and alcohol presumption, a form of which is currently available in the Drug-Free Workplace Program.

Path to the Future

The recommendations in this report as a whole are a path for Tennessee to grow into an exemplary workers' compensation system, one that would be the standard of excellence in the southeast region of the United States. A comprehensive transformation holds substantial benefits for both employers and employees. Employers would enjoy lower insurance costs and less administrative headaches. Employees would get sure, swift, and certain handling of their injury claims and appropriate, high-quality medical care. The State of Tennessee would become a more attractive place to work and do business.

The barriers to achieving this win-win outcome are obvious. Change upsets the status quo. New incentives and rules will change the way claims are handled. All this invites opposition by special interests. A second obstacle is the financial and staff commitment required for the hard work of implementation. Few of these recommendations can be successfully put into practice without skillful crafting of statutes and administrative rules that clearly describe what is expected of injured workers, employers, claims handlers, attorneys, and medical professionals. We have no doubt the Division is eager to make improvements in the system, but the tasks of properly implementing major reforms are daunting and require significant staff resources. More detailed discussion is given in the report to rule making and education.

Introduction

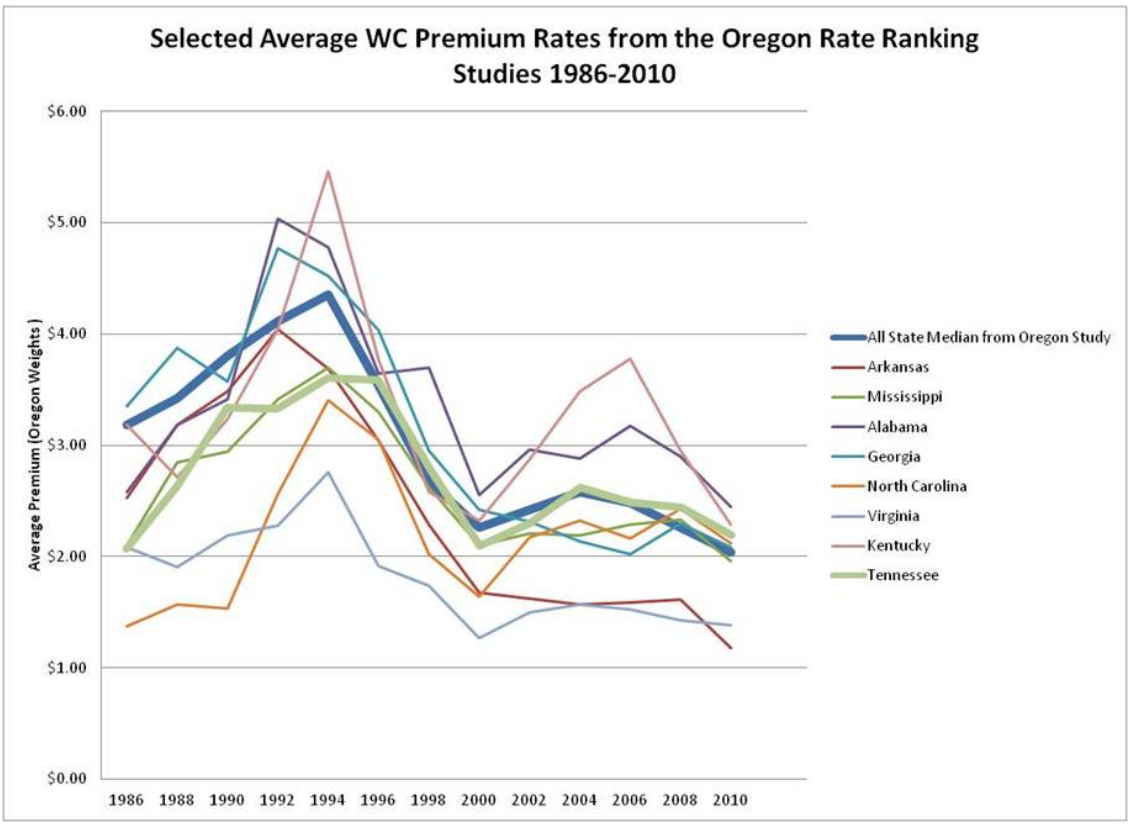
This section begins by providing the reader with the context useful to understanding this report. Following this is a brief statement of objectives set out by the State for this study. Next there is an outline of the methods and guiding principles used by the authors to arrive at the recommendations. Finally, there is a presentation of some caveats and qualifications regarding the application of these recommendations.

State workers' compensation programs are designed to provide a known level of benefits to employees who suffer workplace injuries. In the early 1900s, states began enacting laws to create these programs; Tennessee's program was enacted in 1919. The basic premise of workers' compensation is that, without regard to fault of either the employer or the employee, employees receive medical treatment and income replacement for workplace injuries. With a few exceptions, employers pay for these benefits and are required to insure their liability. In exchange for this no-fault provision of benefits, employees are barred from suing their employer in tort.

Both medical care and industry have experienced dramatic changes since the enactment of these laws, and the laws have adapted to these changes. Some examples of these adaptations include the expansion of coverage for diseases, psychological injury, and repetitive trauma injury. Moreover, medical care professionals continually provide newer and more effective treatment, which has resulted in sharply and steadily rising costs of medical care in workers' compensation cases.

Additionally, almost without exception, state courts have interpreted workers' compensation laws "remedially," in an effort to provide broad coverage and benefits to injured workers. Most courts apply this principle as part of the development of their respective state's common law; in Tennessee, this principle is written into the statute. As a result, coverage and benefit expansions have occurred over the years based on this interpretive principle. All of these types of expansions and changes have placed tremendous pressure on policymakers to consider reform to better control costs and provide predictability in the law.

Major reforms of workers' compensation systems are often driven by employer complaints of high relative cost of a given state's system in comparison to competitor states. In Tennessee, many business leaders have voiced this complaint. A well-used metric of performance, particularly among employers, is the cost of workers' compensation insurance, as measured by rate per hundred dollars of payroll. The State of Oregon publishes a well-known and accepted standard for measuring one state's average insurance rate (over all employer types) with other states. This publication is the basis for the insurance cost trends shown in the diagram below.



Source: Oregon Workers' Compensation Premium Rate Ranking Summary, various years; compiled by Terry Bogyo.

As the above exhibit shows, Tennessee was 3rd lowest among neighboring states (and well below the median of all states in the Oregon study) in 1994, a year in which rates were very dispersed, but rose to 3rd highest in the region in 2010. This rise in the relative position of Tennessee comes despite a cumulative reduction in approved loss cost filings between 2008-2012.[2] Insurers in other states appear to be dropping rates faster than reductions in Tennessee. This movement in Tennessee's relative position helps to explain employer complaints about high costs in Tennessee.

Yet, the figure also shows that there has been a convergence of state rates in recent years, so that the difference between one state and another is far less pronounced than in the mid-1990s. It should also be noted that, in general, the cost of workers' compensation as a percentage of payroll has been declining for Tennessee and most other states in the region.

[2] NCCI makes annual recommendations to the Tennessee Commissioner of Insurance and the Tennessee Advisory Council on Workers' Compensation as to what should be accepted as projected loss costs for the upcoming policy year. Between 2008 and 2012 the average annual loss cost adjustments were a negative 1.96%, essentially saying that insurance company loss payments and loss adjustment expenses were estimated to be slightly declining over this period.

Relative insurance cost is but one standard for measuring system performance. A state can achieve low cost by paying extremely low benefits and restricting claims, but this might fail the standard of fairness. Other standards that states should be measured against include how well they avoid unnecessary disability of injured workers, how quickly they pay benefits, how well medical care responds to injury, how well benefits replace lost earnings, how much litigation they have, and how well they promote safety. All of these standards should be considered in formulating recommendations for change.

Objective and Scope of Study

The objective of this study was to have an outside consultant with strong experience in workers' compensation conduct a comprehensive examination of the Tennessee system and recommend changes that would make Tennessee more competitive as a place to do business, maintain balance between the rights and benefits afforded to both labor and management, and improve the efficiency and effectiveness of the system.

Methods and Principles

This report is the distilled wisdom of numerous experts and stakeholders that shared their insights with the authors. Our main approach was to listen to these stakeholders and capture their greatest frustrations and problems in dealing with the Tennessee workers' compensation system. Oftentimes, these discussions included comparisons with how workers' compensation cases are handled in other states.

This listening moved into problem resolution. "How can we fix that?" was asked over and over. In fairness, it must be said that most of the recommendations made here are taken almost directly from ideas expressed by the experts we contacted.

Besides listening to Tennessee experts, we made extensive use of published materials. These sources provided a way to target reforms at the greatest problem areas. They also helped to show where Tennessee was performing reasonably well relative to other states. Chief among the sources for measuring performance were the Workers Compensation Research Institute (WCRI) and the National Council on Compensation Insurance (NCCI). They are cited extensively throughout this report.

The project team has reviewed workers' compensation cases and statutes across the country, paying particular attention to areas of recent reform. For example, states have recently adopted provisions modifying the definition of "injury" to adjust the standard of proof; other states have added provisions regarding "liberal interpretation." These changes have been of particular interest and focus to the project team in forming the recommendations.

Division staff members were an especially rich source of information. Our understanding of the law, regulatory duties of the Division, and areas of stakeholder concern was amplified by numerous contacts with the Division Administrator and staff. The Division supplied enormous information on utilization review, fee schedules, dispute methods and processes, sources of disputes, and staffing and personnel. Members of the Reform Working Group, acting as a steering committee for this consulting engagement, provided thorough and frequent feedback on questions and helped us focus our attention on priority issues for this report.

Of crucial importance was feedback from stakeholders. Before our consulting engagement, the Reform Working Group conducted numerous feedback sessions and carefully documented points of concern and consideration. Injured workers, employers, defense and claimants' attorneys, providers, insurers, adjusters, and trade groups all provided input. We used this record of stakeholder input. We also benefited from several follow-up calls and conferences with highly expert stakeholders to validate our assumptions and better understand root causes of concerns.

The project team met in Nashville on two separate occasions, once at inception of the project and once after delivery of the Preliminary Report. These sessions provided invaluable and instructive input on the approach and assumptions of the project team.

Data from the Tennessee Advisory Council on Workers' Compensation proved invaluable in gaining insight into Tennessee's program. The Division provided data and statistics in several areas. Both the Advisory Council and the Division are to be commended for their efforts to collect data and make use of it to measure system performance. Other sources of Tennessee specific data included NCCI and WCRI reports. Both organizations have applied considerable expertise in studying the Tennessee system, specifically the effects of previous reforms. Their data on interstate comparisons was also quite useful. The Tennessee Unemployment Insurance Program provided insight into relevant practices. Finally, numerous national studies and projects were considered, and several leading experts in workers' compensation were consulted.

Inescapably, the recommendations are colored by the authors' judgments. Our team has over 100 years of direct experience working with state workers' compensation administrative agencies, including almost 40 years in executive positions in state agencies. Our team has particular expertise in workers' compensation claims handling, insurance practices, dispute resolution and management, mediation, medical and disability management, information systems, and research. We have also been a part of workers' compensation reform efforts in many other states. Thus, we applied professional judgment in sifting and modifying recommendations advocated by stakeholders.

Some of the principles we applied in formulating recommendations for improvement included:

- Simplify and clarify overly complex systems.
- Provide strong incentives for desirable behavior and disincentives for counter-productive behavior throughout the claim process.
- Model best practices of other states.
- Strive to make the system as "self-executing" as possible.

By following these design principles the amount of friction in the system can be greatly reduced, which would equally benefit both workers and their employers.

Difficulties of Implementation

The many recommendations made here will require fundamental changes to Tennessee law and administrative practices. Some of the recommendations point to specific changes to rules. Others are more general pointers to the direction the law should take. Before putting any of these recommendations into law, there must be a careful examination of all the parts of Tennessee law that will be touched by the changes.

The recommendations made here would require some careful statutory language and a large amount of rule making. We have tried to emphasize, particularly in connection with changes to statutory construction and causation, that legislative intent in statutory changes must be very carefully considered. We believe that the majority of recommendations can be implemented through rules, provided that sufficient statutory authority is given to the Division.

Implementing the recommendations would involve an unprecedented amount of rule making. Rule making is a long and difficult process. It is all the more difficult if the rules are carefully crafted to make the duties of parties and processes very clear. Those obligated to perform functions (e.g., claims adjusters or treating physicians) should be clearly instructed. Also, unintended consequences can be avoided by soliciting input from Division staff and stakeholders on issues that need to be considered in rule making. They will doubtlessly raise many questions that will need to be answered. All this will require a substantial amount of staff time, and also expert input from attorneys skilled in writing administrative rules.

Both before and after rules are put into place, there needs to be a carefully orchestrated education program for regulatory staff and those who are affected by the new laws. This education must precede the effective date of the law. Even with proactive education, there will inevitably be a large volume of questions and requests for assistance in understanding the new laws. The Division must be prepared for this need to coach stakeholders through the changes. Of equal importance will be careful tracking of

system performance measurements (what we term “metrics”) by the Division, both before and after changes are implemented. This will provide invaluable insight into whether changes are having their intended effect, as well as to identify other potential unintended consequences.

Finally, the implementation of these reforms will present the management of the Division with an extremely challenging change management problem. The day-to-day workloads currently handled by staff will not be diminished during the change to new rules and procedures. Diverting substantial staff time to rule making and stakeholder education and preparation thus raises workload problems. Making the change management process even more challenging is the inevitable stress of reorganization. The new adjudicatory role will require substantial personnel changes. This means carefully re-writing job descriptions and recruitment procedures, as well as developing additional job training. Facing these daunting tasks, it may be advisable to phase implementation of some reforms. In addition, supplemental resources may be needed by the Division to assist in rule making and design of education and stakeholder communication programs.

Modifying the "Liberal Construction" Interpretation

Issue

A principle concern of various stakeholders considering reform in Tennessee has been the impact of Tenn. Code Ann. 50-6-116. The provision calls for the "equitable construction" of the law in light of the remedial nature of the statute. Tennessee courts have interpreted this provision to require that the Workers' Compensation Law be "liberally and equitably construed in furtherance of its purposes and in favor of compensation." *Coleman v. St. Thomas Hosp.*, 334 S.W.3d 199 (Tenn. S. Ct. 2010).[3]

Employer stakeholders have expressed two separate concerns. First there is a concern that the liberal construction provision has been taken by the Tennessee courts as an implied invitation to the judiciary to interpret the law in ways that were not necessarily contemplated by the Legislature.[4] Second, there is a concern that the section may be used to frustrate attempts by the Legislature to modify benefits, constrain costs or otherwise manage the workers' compensation system's impact on economic growth and opportunity in Tennessee.[5]

Background

Each of these concerns appears to have some factual grounding. Court decisions suggest a willingness to utilize the provision to reach results that were not reasonably

[3] The language was originally passed in 1919, as part of the original enactment of workers' compensation legislation. Historically, many statutes of that era were correctly called "remedial" in the sense that they were creating the first social insurance program in the United States. These laws were abrogating the common law right to sue for civil damages, and the standard principle of statutory construction was that such laws must be "strictly construed." The early workers' compensation laws sought to avoid that strict interpretation, and provide an allowance for unintended interpretations of the law. See *Williamson v. Baptist Hospital of Cocke County, Inc.* (Supreme Court 2012). Since that time, after nearly 100 years of interpretation in Tennessee jurisprudence, such provisions would appear to be no longer necessary, as workers' compensation concepts and laws are no longer new, but far more settled.

[4] There is another concern that should be considered as well. Liberal construction, by its nature, serves as an invitation to litigants to test the parameters of the law and also acts as an invitation to the courts to react creatively when the facts of a case do not easily fit the pattern of law developed to that time. These invitations create uncertainty with respect to the payouts that can be expected on insured occupational exposures, and thus the premiums that must be collected to cover these payments. To the extent that insurance companies foresee payment uncertainty they may build risk premiums into their charged rates for particular industries subject to the uncertain court rulings, or to rates generally for the state. Volatile law is also a consideration for insurers in whether to underwrite new business in a particular industry or in a particular state.

[5] Note that some interpretations of Tenn. Code Ann. 50-6-116 have limited the "liberal interpretation" principle to exclude matters of practice and procedure. *Tenpenny v. Batesville Casket Co.*, 781 S.W.2d 841 (Tenn. S. Ct. 1989). Regardless, to avoid confusion, it is appropriate to provide clarity on all issues of workers' compensation.

anticipated. For instance, in *Nichols v. Jack Cooper Transport Company* (Tenn. S. Ct., Aug. 27, 2010) the Supreme Court found that it had a "unique opportunity" to interpret together the provisions of the cap on permanent partial disability and the provision allowing reconsideration of a prior benefits award. The reconsideration provision is specifically limited by statute to disallow reconsideration on the basis of the voluntary resignation or retirement of the employee. The Supreme Court found, citing among other things the liberal construction provision, that the circumstances of the employer's multiple return to work offers were not sufficiently attractive to the employee, who was laid off but ultimately retired, even though the employee admitted that at least one refusal was based only upon geographical preference. As a result, the employee's refusal to return to work did not constitute a voluntary termination or retirement. The award was reconsidered and the higher cap on permanent partial disability benefits was used. This occurred despite the Court's recognition of the clear statement of the General Assembly in its 2004 workers' compensation reforms that the intent of the reforms, including the cap and reconsideration provisions, was to create cost savings for employers and see them passed on in the form of insurance premium adjustments. In this instance, however, the explicit statutory instruction to construe equitably was deemed controlling over the statement of legislative intent that the savings created by the reforms be passed on to employers.

Similarly, in *Padilla v. Twin City Fire Insurance Co.* (Tenn. S. Ct., Oct. 6, 2010) Justice Wade (dissenting) made the following statement concerning the current status of Tennessee law:

> A basic principle of the Workers' Compensation Act ("the Act") is its remedial purpose. Tenn. Code Ann. 50-6-116 (2008); *Trosper v. Armstrong Wood Products*., 273 S.W. 3d 598, 609 n.5 (Tenn. 2008). For years, this Court has interpreted this statutory mandate to favor the employee under circumstances where there is "reasonable doubt" surrounding the compensability of a work-related claim.

This interpretive principle creates circumstances where the predictability of claim outcomes in court is diminished and where litigation is pursued as to such "reasonable doubt." Additional litigation causes delays in case resolution.

It is difficult to know the impact of the "liberal interpretation" principle, in terms of: (a) costs[6]; or (b) inviting litigation. What is clear, however, is that it is no longer as

[6] It is clear that some states have seen workers' compensation premium and loss rates drop after major reforms that included repeal of the "liberal construction" principle, such as in Arkansas. According to the bi-annual survey of workers' compensation premiums published by the State of Oregon Department of Consumer and Business Services, Workers' Compensation Division, Arkansas had the 34th highest premiums in the US in 1994 (the year after adoption of the strict liability provision). By 2002, the Arkansas premium rating had improved to 47th highest in the country. It is also clear, however, that such trends cannot reasonably be attributed to repeal of that provision alone. The National Council on Compensation

necessary as it was at the dawn of novel workers' compensation laws, to correct unintended "inequity" from legislation, as workers' compensation concepts and laws are now much better settled and legislative intent less in doubt. Moreover, additional clarity and predictability in the law helps reduce litigation.

Tennessee is somewhat unique in including a statutory provision requiring an "equitable construction" and declaring the workers' compensation law to be "remedial" in nature. In most states, this is applied as a common-law interpretative principle. Kansas is an example of a state with a statutory provision addressing this issue. Prior to recent reforms, Kansas Stat. 44-501(g) provided as follows:

> It is the intent of the legislature that the workers compensation act shall be liberally construed for the purpose of bringing employers and employees within the provisions of the act to provide the protections of the workers compensation act to both. The provisions of the workers compensation act shall be applied impartially to both employers and employees in cases arising thereunder.

In 2011, this provision was replaced with a slightly different version, Kansas Stat. 44-501b(a), which reads:

> It is the intent of the legislature that the workers compensation act shall be liberally construed only for the purpose of bringing employers and employees within the provisions of the act. The provisions of the workers compensation act shall be applied impartially to both employers and employees in cases arising thereunder.

The change added the word "only" and struck "to provide the protections of the workers' compensation act." California is another example of a state with a "liberal construction" provision in its workers' compensation law. Cal. Labor Code 3202.

Other states have addressed this issue by enacting provisions stating that the law should be interpreted "neutrally" or even "strictly," and sometimes stating that it should not be interpreted "liberally." For example, in 2012 Louisiana enacted the following provision in La. Stat. 23:1020.1(D):

> Disputes concerning the facts in workers' compensation cases shall not be given a broad, liberal construction in favor of either employees or employers; the laws pertaining to workers' compensation shall be

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Insurance (NCCI) does not factor explicitly the effects of changing the causality standard into estimates of loss costs, citing the difficulty of isolating and predicting law induced changes in claims cost. NCCI takes the position that it has not found definitive support for quantifying cost impacts from such legislative changes. Instead, impacts on costs would be reflected in future loss experience.

> construed in accordance with the basic principles of statutory construction and not in favor of either employer or employee.

Similarly, Mississippi Stat. 71-3-1 was amended in 2012 to provide as follows:

> [T]his chapter shall be fairly and impartially construed and applied according to the law and the evidence in the record, and, notwithstanding any common law or case law to the contrary, this chapter shall not be presumed to favor one party over another and shall not be liberally construed in order to fulfill any beneficent purposes."

Other similar statutory enactments include Florida (2003), West Virginia (2003) Missouri (2005), Arkansas (1993), and New Mexico (1990).

The New Mexico change added N.M. Stat. Ann. 52-5-1, which provides in relevant part as follows:

> It is the specific intent of the legislature that benefit claims cases be decided on their merits and that the common law rule of "liberal construction" based on the supposed "remedial" basis of workers' benefits legislation shall not apply in these cases. The workers' benefit system in New Mexico is based on a mutual renunciation of common law rights and defenses by employers and employees alike. Accordingly, the legislature declares that the Workers' Compensation Act and the New Mexico Occupational Disease Disablement Law are not remedial in any sense and are not to be given a broad liberal construction in favor of the claimant or employee on the one hand, nor are the rights and interests of the employer to be favored over those of the employee on the other hand.[7]

In 1995, Tennessee Senator Gene Elsea introduced Senate Bill No. 860 (introduced with House Bill 1325, by Rep. Ronnie Cole), which replicated some language from the 1990 New Mexico law. This bill, which was ultimately defeated in committee, sought to delete the Tenn. Code Ann. 50-6-116, and replace it with the following provision:

> It is the intent of the legislature that the workers' compensation law be interpreted so as to assure the quick and efficient delivery of disability and medical benefits to an injured worker and to facilitate the worker's return to gainful reemployment at a reasonable cost to the employer. It is the specific intent of the legislature that workers' compensation cases

[7] In 1993, Arkansas, as part of its reform package, enacted the following provision in 11-9-1001: If the "scope of the workers' compensation statutes need to be liberalized, broadened, or narrowed, those things shall be addressed by the General Assembly and should not be done by administrative law judges, the Workers' Compensation Commission, or the courts."

> shall be decided on their merits. In addition, it is the intent of the legislature that the facts in a workers' compensation case are not to be interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Additionally, the legislature hereby declares that disputes concerning the facts in workers' compensation cases are not to be given a broad liberal construction in favor of the employee on the one hand or of the employer on the other hand, and the laws pertaining to workers' compensation are to be construed in accordance with the basic principles of statutory construction and not liberally in favor of either employee or employer. It is the intent of the legislature to ensure the prompt delivery of benefits to the injured worker; therefore, an efficient and self-executing system must be created which is not an economic or administrative burden. The workers' compensation division, appeals board, and courts therefore have the duty to administer and interpret the workers' compensation law in a manner which facilitates the self-execution of the system and the process of ensuring a prompt and cost-effective delivery of payments.

Finally, it is important to consider the possible impact of such reforms on workers' compensation exclusive remedy provisions. Specifically, does a "strict interpretation" of the workers' compensation act provide an opening for suits in civil court, when the strict interpretation has the unintended consequence of not covering a person or condition that likely was intended to be covered? Missouri enacted major workers' compensation reforms in 2005, which repealed a "liberal interpretation" provision and adopted a requirement that required courts to "construe the provisions of this chapter strictly" Mo. Stat. 287.800. In *Robinson v. Hooker*, Case No. WD71207 (Mo. Ct. App., Aug. 3, 2010), the court, citing the new strict interpretation requirement, allowed an injured worker to pursue damages in civil court against a co-employee. The injury was allegedly the result of the co-employee's negligence. Typically, co-employees have been immune from suit for injuries caused by their negligence. The court held, however, that because co-employees were not specifically included in the exclusive remedy provision (only "employers" were listed there), strict construction required that the suit be allowed. The Missouri General Assembly has since modified the law to disallow such suits.

Although not precisely on point, subsequent to New Mexico's adoption of a "neutral interpretation" standard quoted above, the New Mexico Supreme Court, in 2009, held that an employer enjoyed the exclusive remedy provision, but affirmed that the provision was subject to attack under a common-law created "intentional act" exception. In other words, if an employer "intentionally" performed an act that harmed an employee, the employee could sue the employer in civil court. This exception was not part of the statutory exclusive remedy provision. Importantly, the court did not explain whether it must strictly construe the exclusive remedy provision, but it is instructive that such a common-law exception to the statute continues to hold, and it reasonably can be expected that such interpretations would continue in New Mexico,

despite the "neutral interpretation" change in 1990. Tennessee courts have applied a similar common-law principle allowing intentional tort actions against employers despite the exclusive remedy provision. *See, e.g.*, *Cooper v. Queen*, 586 S.W.2d 830 (Tenn. Ct. App. 1979).

It is important to understand that changing from liberal or equitable construction of a statute to another standard creates the opportunity to test the new standard in court. The interpretations of the court may involve consequences not foreseen by the sponsors of the new standard. Any alleged injury at work that is judged to be non-covered under workers' compensation may open the door for a civil suit to recover damages. This uncertainty of judicial interpretation prompted the American Insurance Association to warn of unintended consequences from changing the statutory standard for interpreting the workers' compensation statute.

Recommendations

We recommend that the current statutory authorization regarding "equitable construction" be replaced with a statement that the Legislature intends the workers' compensation law, in its entirety, to be interpreted in a manner that is neither favoring of workers nor favoring of employers, but that is neutral and even handed. It is suggested that the language of 1995 SB860 be used as an appropriate starting place.

We believe that such a "neutral" as opposed to "strict" mandate (as in Missouri) potentially helps prevent unintended consequences regarding the exclusive remedy provision. An additional assurance, however, is to also modify the exclusive remedy provision to extend its protections to those parties who, through common law, enjoyed its protections, such as co-employees, as well as to provide for recognized common-law exceptions to the exclusive remedy provision, such as for intentional acts.

Expected Outcomes

The expected outcome of such a change would be to decrease broad and expansive legal interpretations of coverage and other workers' compensation issues in Tennessee, and add predictability and consistency to the law. Achieving this outcome can be measured by regular review of cases interpreting the law.

Setting a Clearer Standard for Causation

Issue

There is consensus among employers active in Tennessee workers' compensation policy that benefits are being awarded based on a causation standard that is overly broad. There also is concern that such broad interpretation of the law is leading to unpredictable and inconsistent results, resulting in higher litigation and loss costs. Finally, litigation on this issue causes delays, which harm employees by delaying receipt of treatment and lost wage benefits.

Among the likely sources of this perceived problem, six stand out:

1. The standard for determining whether an injured worker has shown causation is not clear, particularly with respect to pre-existing conditions.
2. Varying interpretations of the standard by Tennessee courts.
3. Multiple, competing "expert" opinions on causation have been allowed, as well as varying weights being applied to both expert and lay opinion.
4. The standard of appellate review is highly deferential on the application of the law.
5. In Tennessee, as in the US generally, injury rates are increasing due to non-occupational forces; the general health of the workforce is not good.[8]
6. Tennessee's workers' compensation law is being interpreted "remedially," with seemingly strained decisions of causal connection.

Some of these were addressed by Tennessee statutory changes in 2011 (SB 932). Regardless, the causation issue is closely connected with several other concerns, and requires careful consideration in the context of recent law changes.

Background

In the early 1900s, when workers' compensation laws were being enacted across the country, in many respects coverage issues were more straightforward because the focus was on "traumatic injury." Over the years, this was broadened to include disease, psychological injury, strains, cumulatively occurring injury, and other conditions for which it is more difficult to find a precise cause of injury or harm.

Routinely, workers' compensation laws are modified to further define the claims of injury that should be covered by workers' compensation law. Tennessee and its surrounding states all use the same starting point for a compensable injury, namely, one that "arises out of and in the course of employment." Judicial interpretations of "arising

[8] In *Health, United States, 2011*, the CDC reports increases in heart disease, hypertension, and obesity, and in the rate of general "fair or poor health." See: Table: "At a Glance," p. 1 (U.S. Dep't of Health and Human Services, May 2012).

out of the employment" vary widely throughout the nation. In civil liability, absent a presumption being applied, the proponent of an issue bears the burden of proof and typically the standard of proof is a "preponderance of the evidence." In recent workers' compensation reforms, the basic "preponderance" standard has been yielding to a concerted effort by some legislatures to enact a stricter standard.

Employer interests in Tennessee have called for similar reforms, citing Tennessee courts' liberal interpretations of the standard of proof in workers' compensation cases. For example, in *Reeser v. Yellow Freight*, 938 S.W.2d 690 (Tenn. S. Ct. 1997), the Court, in awarding benefits in a stroke claim, reasoned that it had "consistently held that an award may properly be based upon medical testimony to the effect that a given incident 'could be' the cause of the employee's injury, when there is also lay testimony from which it reasonably may be inferred that the incident was in fact the cause of the injury." The injured worker in *Reeser*, a 63-year old with severe pre-existing coronary artery disease, suffered a stroke while driving in precarious storms and presented medical evidence that such activity "could have triggered" the stroke. This "could have caused" standard is an issue raised by many employer stakeholders.

Recent Causation Reforms

In response to what employers regard as overly broad court interpretations, there is a nationwide drive by some employer groups to move to a "primary contributing cause" standard, as pioneered by Oregon. In 1996, Oregon modified its definition of "injury" as follows:

> If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition.[9]

In 2000, Oregon sponsored a comprehensive study of the impact of this reform, which concluded as follows: "There is considerable evidence that the statutory changes in the workers' compensation statute in Oregon since the mid-1980s have significantly reduced payment to workers and reduced costs to employers."[10] In that report Edward Welch estimated that benefits were 13% lower in 1996 than they would have been in the absence of the 1990 changes.

[9] This definition is currently set forth in Or. Stat. 656.005(7)(a)(B).

[10] Edward Welch, "*Final Report, Oregon Major Contributing Cause Study," Michigan State University,* Oct. 5, 2000, p 151.

Arkansas, Florida, and South Dakota adopted similar provisions to Oregon's during the same period. More recently, Kansas, Mississippi, Missouri, and Oklahoma [11] have also followed this standard.

For example, Kansas recently added provisions on the standard of causation:

> An injury by accident shall be deemed to arise out of employment only if: (i) There is a causal connection between the conditions under which the work is required to be performed and the resulting accident; and (ii) the accident is the prevailing factor causing the injury, medical condition, and resulting disability or impairment. . . "Prevailing" as it relates to the term "factor" means the primary factor, in relation to any other factor. KSA 2010 Supp. 44-508(f).

There are also efforts to specify particular conditions, such as mental injuries, gradually incurred injuries, diseases of life, and heart attacks, and provide stricter causation standards. Others are focused on "pre-existing conditions." While recent reforms in Kansas sought to exclude pre-existing conditions from the definition of a compensable injury,"[12] other states have focused on the distinction between causing an *injury* and causing *disability*. For example, in Alabama, the focus is on the degree of disability caused by the pre-existing condition, as opposed to compensability: "If the degree or duration of disability resulting from an accident is increased or prolonged because of a preexisting injury or infirmity, the employer is liable only for the disability that would have resulted from the accident had the earlier injury or infirmity had not existed." Ala. Code 25-5-58.[13]

Other statutory provisions make specific reference to the "natural process of aging" and other "life issues," which clearly are a significant contributor to the incidence of injury and disability. For example, in Kentucky, "injury" is defined to exclude "the effects of the natural aging process, and does not include any communicable disease unless the risk of contracting the disease is increased by the nature of the employment." KY Statute 342.0011(1). Florida has enacted similar provisions (see Fla. Stat. 440-09(1)), as has Arkansas (see Ark. Code 11-9-102(4)(F)(ii)(b)) and Wyoming (see Wyo. Stat. 27-14-102(11)(G)).

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[11] A basic description of the standards in these states would be: Kansas (prevailing factor); Mississippi (significant contribution); Missouri (prevailing factor); and Oklahoma (major cause). Other statutory provisions call for such particular standards in other respects, such as pre-existing conditions, repetitive trauma, and heart, stress, and mental injuries.

[12] "An injury is compensable only if it arises out of and in the course of employment. An injury is not compensable because work was a triggering or precipitating factor. An injury is not compensable solely because it aggravates, accelerates or exacerbates a preexisting condition or renders a preexisting condition symptomatic." Kan. Stat. Ann., 2010 Supp. 44-508(f).

[13] Note that for permanent impairments, pre-existing conditions are routinely excluded in calculating impairment caused by a work injury. See, e.g., Va. Code 65.2-505.

Causation and Evidentiary Proof

Other statutory limits on causation determinations have involved placing limits on who is allowed to provide credible evidence on the issue, and how this evidence must be presented. For example, in Florida, "Pain or other subjective complaints alone, in the absence of objective relevant medical findings, are not compensable." Fla. Stat. 440.09(1). "Objective relevant medical findings" are defined as "those objective findings that correlate to the subjective complaints of the injured employee and are confirmed by physical examination findings or diagnostic testing." *Id*.[14] Furthermore, Florida defines the standard of medical evidence as follows: "The injury, its occupational cause, and any resulting manifestations or disability must be established to a reasonable degree of medical certainty, based on objective relevant medical findings…." *Id.*

Similarly, in Wisconsin, the attending physician's report contains the following instructions:

> The questions on the WKC-16-B concerning causation and disability are to be answered to a "reasonable degree of medical probability." The Worker's Compensation Law does not require 100 percent certainty. The standard is a reasonable degree of medical "probability" meaning "more likely than not," as opposed to speculation or a mere possibility. On the basis of the information available to doctors, they should decide whether it is more likely than not that an event or series of events caused the injury and whether the injury caused the disability.[15]

Clarifications as to the burden of proof, in addition to the standard of proof, have also been enacted. For example, in Indiana, the workers' compensation act provides as follows: "Every employer shall pay and every employee shall accept compensation for personal injury or death by accident arising out of and in the course of the employment. The burden of proof is on the employee. The proof by the employee of an element of a claim does not create a presumption in favor of the employee with regard to another element of the claim." Ind. Stat. 22-3-2-2(a).

Causation and Recent Tennessee Statutory Changes

Tennessee has recently enacted limits with respect to determinations of causation. In 2011, in the definition of "injury," the following limitation was added: "An injury is 'accidental' only if the injury is caused by a specific incident, or set of incidents, arising

[14] Moreover, if the condition is not "readily observable," then the causal relationship must be "demonstrated by physical examination findings or diagnostic testing." Fla. Stat. 440.09(1). The "major contributing cause" of an injury "must be demonstrated by medical evidence only. *Id.*

[15] Wisconsin *Physician's Report on Accident or Industrial Disease in Lieu of Testimony*, Form WKC-16-B, available at http://dwd.wisconsin.gov/dwd/forms/wkc/wkc_16_b_e.htm.

out of an in the course of employment, and is identifiable by time and place of occurrence." 50-6-102(11)(A)(i). Also in 2011, "repetitive motion conditions" were excluded from the definition of "injury," "unless such conditions arose primarily out of and in the course and scope of employment." 50-6-102(11)(C)(ii). Tennessee also recently enacted limitations on which evidence is most credible in causation determinations: "The opinion of the [panel] physician . . . shall be presumed correct on the issue of causation, but said presumption shall be rebutted by a preponderance of the evidence." Other related limits in Tennessee include those on mental injuries. Heart-attack claims, which are often limited by requiring a connection with a physical injury or "extraordinary" exertion, such as in Oklahoma, are not limited by statute in Tennessee.[16]

Related Issues

Contributing to what was perceived as an expansion of conditions covered by workers' compensation in Tennessee is the "liberal construction" of causation under Tennessee law. There is concern that without change in the "liberal construction" provision, litigants might find ways to severely weaken the intent behind efforts to set boundaries on the causation standard. They fear that the courts may soften, mitigate, or work around terms like "predominant," "correlate," or "objective evidence."[17] Thus, if the causation changes are to be applied as intended, the "liberal construction" standard in Tennessee law should be changed.

An additional concern is the degree to which courts adhere to legislative intent in making such changes, and also the adherence to case law. Some states have enacted codifications of legislative intent in undertaking major reforms on these issues, with others even calling for annulment of case law. See, e.g., Ark. Code 11-9-1001.

In summary, there is a growing concern among payers that workers' compensation programs are inappropriately burdened with non-occupational conditions. There is a

[16] Okla. Stat. 85-308(10) provides as follows:

> "Compensable injury" means a cardiovascular, coronary, pulmonary, respiratory, or cerebrovascular accident or myocardial infarction causing injury, illness, or death, only if, in relation to other factors contributing to the physical harm, a work-related activity is the major cause of the physical harm. Such injury shall not be deemed to be a compensable injury unless it is shown that the exertion of the work necessary to precipitate the disability or death was extraordinary and unusual in comparison to the usual work of the employee, or alternately, that some unusual incident occurred which is found to have been the major cause of the physical harm.

[17] We cannot predict how Tennessee courts will interpret these new standards and terms for causation. Related to this, we address the direction of public policy on construction of the law in another section of this report.

countrywide perception that employers are being forced to pay for disabling conditions that are not work related, but rather caused by other life events or pre-existing conditions. In support of their concerns, there is good evidence that the general physical condition and health of the workforce is contributing to claims for workers' compensation and the duration of disability. This shift of responsibility for lifestyle and aging process issues to the occupational compensation system appears to employers as a cost of doing business that puts them at a competitive disadvantage. The growing tendency of state legislatures to tighten causation standards indicates that these employer concerns are being accepted in public policy.

Recommendations

At first glance, it appears that recent changes in Tennessee with respect to causation, discussed above, are in line with other state reforms to place limits on expanding causation determinations. The limits placed on "repetitive motion conditions" fit within reforms designed to address pre-existing conditions and injuries of ordinary life and aging. The deference given to the panel physician also supports objective determination of causation based on medical evidence. The changes to the definition of injury to require incidents that are "identifiable by time and place of occurrence" are designed to place limits on non-specific and non-physical incidents. Disability duration caps on mental injuries and injuries for persistent pain serve to place limits on difficult-to-define conditions. All this demonstrates a clear public policy direction in Tennessee to make work injury compensability more objectively tied to work and easier to adjudicate.

Additional modifications, however, are needed to clearly align the responsibility of workers' compensation for injury and disease with some arguable connection to the workplace:

- The definition of injury should be changed to require proof that injury "arose primarily out of and in the course of employment."
- Define "primarily" to mean "considering all the causes, as shown to a reasonable degree of medical certainty, the employment contributed more than 50% in causing the injury and resulting disability and treatment."
- Modify in the same manner the "disease" definition in Tenn. Code 50-6-301.
- The standard of proof should be clarified by a section stating that "reasonable degree of medical certainty" is required, such as in Florida and similar to the Wisconsin example, and defining "reasonable degree of medical certainty" to mean, "considering all the causes, more than 50%, as opposed to speculation or possibility, that the accident caused the injury and any resulting disability or treatment."
- The burden of proof should be clearly established, such that the injured worker bears the burden of proving causation, as in Indiana.

- Heart attack and stress injuries should have a similar definition as "mental injury" in 50-6-102(15), and all should have the "arose primarily out of the employment" standard.[18]

These changes should be made in connection with other reforms, such as clarifying the role of the appellate courts and eliminating the liberal construction provision.

Expected Outcomes

The expected outcome of undertaking such reforms would be:

- Fewer cases where "possible" causally connected injuries are covered by workers' compensation.[19]
- Clearer standards of proof being applied, reducing litigation and making the application of the law more straightforward.
- Lower incidence of "diseases of life" being inappropriately attributed to workplace injuries, when the evidence shows that such conditions cannot fairly be assigned, in the aggregate, to a specific injury.
- More stable and even reduced benefit costs.
- Although not an impact on workers' compensation, some costs that are removed from workers' compensation will shift to other medical benefit and income-loss coverage systems. For example, employers with disability income policies might expect higher claims frequencies for injuries deemed non-work related, and group health policies might see similar cost increases.[20]

These outcomes should be measured by tracking disputed issues and denial reasons, over time, to discern trends of disputed issues.

[18] Special care should be taken, in enacting changes to such definitions, to avoid creating anomalies with current presumption provisions available for certain law enforcement officers and firefighters for heart and lung conditions. Tenn. Code 7-51-201.

[19] It is also likely that causally connected injuries will be improperly excluded from coverage, based on incorrect interpretations "in the field" that the causal connection is too tenuous. This will take time to become established in practice. It would be helpful to emphasize the "frivolous defense" provisions.

[20] It should be noted that the more narrow the application of causation standards, causing more denials of workers' compensation claims, the more likely that tort actions would be entertained by Tennessee civil courts. Causation standards are not typically applied in an "automatic" fashion, as are other standards, such as the "not less than five" employee standard set forth in the definition of employer. Tenn. Code 50-6-102. Thus, causation standards might create issues that will work their way through the courts. *See, e.g.*, Tenser, C., "Recent Challenges to Exclusive Remedy Bend – But Don't Break – the Workers Compensation System," NCCI Issues Report 2005, posted Jan. 28, 2005, available at https://www.ncci.com/documents /IR_Recent_Challenges.pdf. This is not a predominant theme in other states that have adopted narrower causation standards, however.

Structure of Tennessee Workers' Compensation System: "Court" v. "Administrative"

Issue

Further reforms to workers' compensation are a high priority with business leaders and other interest groups in Tennessee. Dissatisfaction with the system is evidenced in the Governor's "listening tours," media stories, and stakeholder meetings hosted by the Division of Workers' Compensation. Among the most frequently cited problems is the role of the court system in workers' compensation. In general, the Tennessee workers' compensation system for resolving workers' compensation disputes is seen by critics as "too litigious" and unpredictable. Additionally, the system is seen as inefficient, taking too long and requiring too many processes. Although recent administrative changes within the Division show real improvements in resolving disputes, there continues to be a stated desire to strengthen the administrative role in dispute resolution and reduce the role of the courts in the workers' compensation system.

Background

The Tennessee workers' compensation program is within the Tennessee Department of Labor and Workforce Development (DOL), overseen by the Commissioner of Labor and Workforce Development, and managed by the Division Administrator of the Workers' Compensation Division. The Administrator of the Division must have five years of "credible experience," have "comprehensive knowledge and experience in the operation of the programs" of the Division, and "be recognized by the representatives of the business and labor communities as a person of good standing and reputation in matters concerning workers' compensation." Tenn. Code Ann. 4-3-1408. The Administrator is appointed by the Commissioner for a four-year term, and may be removed for non-performance of duties. The current term runs from July 1, 2011 through June 30, 2015 (Gov. Haslam began his term on January 15, 2011).

Tennessee has some unusual procedures for resolving disputes over workers' compensation coverage and benefits. First, workers' compensation litigants must use courts of general jurisdiction to try disputes. A related problem is the strategic battle over choice of venue for trial, sometimes called a "race to the courthouse."[21] The Supreme Court recent described the "race" as engaging "attorneys in the undignified spectacle of literally racing to secure perceived procedural advantages" but noted that in "the absence of a legislative solution, we are unable to stop the running of the

[21] When a claim is denied or a benefits review conference reaches impasse, the "race to the courthouse" is triggered, with attorneys calling paralegals to get a filing in quickly (first in wins) in the desired venue. This process was corrected somewhat in 2012 legislative changes, which removed "where the claimant lived at the time the claim was filed" as a venue option.

race."[22]

Another oddity is that employers are required to "exhaust" the administrative process at DOL before getting a final determination of compensability from a court. In practical terms, this means that benefits, such as temporary total disability (TTD), can be paid for years, despite an underlying, dormant dispute about compensability, waiting for "exhaustion" of the DOL administrative process. If the employer prevails on the issue in civil court, the employer can apply for a refund of the benefits paid from the Tennessee Second Injury Fund. This still increases overall system costs unnecessarily, however. This protracted payment of TTD in spite of a challenge to underlying compensability is an oddity of the Tennessee system.

The court-based system appears to lead to some inconsistent practices in workers' compensation litigation across the State. For example, with respect to non-jury civil trials, in FY 2010-211, there were 17,440 such trials across the 31 Tennessee judicial districts, Chancery and Circuit Courts combined, and 152 judges.[23] Of those trials, there were 463 that pertained to workers' compensation,[24] or 2.7% of the total non-jury trials. In one district where a relatively large number of non-jury civil trials were conducted (1172 in District 4), only a small number were workers' compensation cases (6, or 0.5%).[25] On the other hand, some districts have a relatively large number of workers' compensation trials. For example, District 13 had 66 workers' compensation trials out of a total of 509 trials, or 13%.[26] This analysis combines chancery and circuit court trials; the breakdown when analyzing chancery and circuit court separately would produce an equally wide range of results.

There is no available data to explain why there are such varying numbers of workers' compensation trials across the judicial districts in Tennessee. Clearly, some judges are more experienced in workers' compensation, and others less so, as reflected in the volumes. It is also possible that some districts are preferred by litigants for any number of reasons, leading to higher volumes.[27] Regardless of the reason, this wide range of

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[22] *Word v. Metro Air Servs., Inc.*, No. M2011-02675-SC-R9-WC (Aug. 21, 2012).

[23] Annual Report on the Tennessee Judiciary, Fiscal Year 2010-2011, available at http://www.tncourts.gov/ sites/default/files/docs/2010-2011_annual_report_of_the_tennessee_ judiciary_0.pdf. It should be noted that the number of non-jury workers' compensation trials from this report, 463, differs from the number presented in the Statistical Report to the Advisory Council on Workers' Compensation. The Advisory Council report is based on Form SD1 filings with the Division.

[24] During the same period, 105 cases were appealed to the Special Workers' Compensation Panel, 76 cases where the Supreme Court affirmed the Panel, 45 cases where there was an order of dismissal, and 26 cases where motions to the Supreme Court for discretionary review were filed (the Supreme Court granted 1 motion for discretionary review).

[25] Other examples of this are in District 18 (9 out of 1455, or 0.6%) and District 4 (6 out of 1172, or 0.5%). In District 29, there were 467 non-jury trials and no workers' compensation trials.

[26] Similarly, District 9 had 48 workers' compensation trials out of a total of 522 trials, or 9.2%. District 24, which had only 92 total trials, conducted 20 workers' compensation trials, or 21.7%.

[27] The recent legislative change concerning trial venue might impact these numbers.

activity could be evidence of a highly variable approach to workers' compensation trial practice and case outcomes in Tennessee.

In general, the practice of workers' compensation law is highly specialized and unique, not unlike other statutory schemes that involve civil litigation. The leading treatise on the practice, Larson's *Workers' Compensation Law*, consists of 12 large loose-leaf volumes, covering hundreds of tightly coordinated issues. Tennessee's Workers' Compensation Law is similarly complex, part of a lengthy statute applying an interwoven set of administrative law provisions. Conducting only a small number of trials per year on such matters affords judges little opportunity for gaining in-depth experience in workers' compensation issues. Consistency in application of the law by judges likely is impacted by this complexity.

Other issues, such as the subjectivity involved in the use of the multipliers in permanency cases, invite uncertainty and thus litigiousness. A special study conducted by WCRI at the request of the Tennessee Advisory Council concluded that there are wide disparities in workers' compensation caseloads and PPD multiplier awards across judicial districts. That report commented on the lack of familiarity of circuit court judges with workers' compensation PPD benefit determination.[28] Injured workers share the interest of employers in speedy, impartial, and consistent dispute resolution. Additionally, avoiding attorney involvement (except in cases where the complexity compels it) is essential to reducing unnecessary litigation.

As serious as these concerns are for the litigants, the costs to the underlying system are even more significant. There is now a large volume of research literature demonstrating that delays in return to work have a profound impact on the probability that the worker will ever return to productivity.[29] There is also considerable research demonstrating that the health effects of being out of work include more chronic disease, development of debilitating conditions and shortened lifespan. There is a direct relation between the litigious environment for dispute resolution and these results, as studies on three continents demonstrate a strong relationship between the presence of litigation in compensation cases and longer duration of claims, higher costs and other indicia of poor outcomes. This is true even when the study populations have been controlled for injury severity. Thus, the reform of the Tennessee workers' compensation dispute resolution system is a matter of statewide importance, affecting demands on public assistance resources and health care resources in addition to workers' compensation system fairness and costs.

[28] Boden, L., "Permanent Partial Disability in Tennessee: Similar Benefits for Similar Injuries?", WCRI, WC-97-5, December 1997, Cambridge, Mass.

[29] *See generally* Stout, et al. *Current Perspectives in Clinical Treatment & Management in Workers' Compensation Cases*, Chapter 8 (Aurbach) pp. 130-133 (Bentham 2011).

There are several resolution dispute functions currently in place at DOL, and stakeholders agree that these function well from a customer service and professionalism perspective. The Request for Assistance, or RFA process, provides quick assistance on issues, and ultimately results in awards or denials that are consistent and professional. The Benefits Review Conference, or BRC, also provides a more formal mediation experience for parties where MMI is reached.

The Division recently has made some improvements to this process. Stakeholder feedback was collected, including a meeting with Division employees to provide input. Quality control measures, such as timelines for the RFA process and standardized templates to be used by Specialists, have been initiated. Similar changes have been made in the BRC process as well. Education efforts, specifically to provide training to claims handlers, have been well received. The penalty program has also been improved, and steps have been taken to ensure impartiality, and the perception of impartiality, in the dispute resolution process.

Many states use an ombudsman program as a first step in providing a quick way to provide clear answers to questions about the claims process so as to avoid escalation of conflict into formal disputes. Additionally, states often use a mandatory or voluntary alternative dispute resolution system as a second mechanism for the quick resolution of disputes. These systems may be referred to as "mediation," "conciliation" or "arbitration" hearings, and involve a neutral "official" assisting the parties in identifying issues and coming to agreeable terms. They are still informal in nature and have the power to facilitate and document agreements, or in the absence of an agreement, advise the parties of the official's assessment of the weight of the evidence.[30] This provides the parties an additional level of formality and has the impact of leading to final resolution for a significant proportion of cases, without the delay and cost of a trial. This is the case even where participation in the process is voluntary. Examples of "mediation" programs are set forth in the Appendix.

When such informal methods are unsuccessful, a more formal adjudication process is required, and it is essential that it be fair, complete, and expedient. Currently, in Tennessee, the basic process for dispute resolution for denied benefits is for the employee to file an "RFA" or "Request for Assistance" and pursue resolution at DOL, where a DOL Specialist (attorney) reviews the dispute, and either denies the claim, or orders benefits. Tenn. Code 50-6-238. This decision is subject to "Admin Review" which is conducted by a "senior specialist" within DOL. A denial decision exhausts the DOL process, which allows an employee to pursue a remedy in court, either in Circuit Court or Chancery (which are basically the same, and in some areas the same judge is both Circuit Court Judge and Chancellor).

[30] In a sense, this function is a proxy for the common parental function of making a decision about "who was right and who was wrong."

An award, or order of benefits does not exhaust the process, however, and the parties then wait for the injured worker's maximum medical improvement, or MMI, and an impairment rating. If there is not agreement on MMI or the rating, a benefits review conference (BRC) is scheduled with DOL to seek to resolve the issue. The result of the BRC is either settlement or impasse. An impasse "exhausts" DOL involvement, which allows either party to pursue a remedy in court. Tenn. Code 50-6-225. If a case drags on to impasse, significant damage may have already been done to the proper handling of medical care. In *Alstom Power v. Head* (Tenn. Ct. App., Feb. 21, 2012), the Court ruled that there was no opportunity to review an order pertaining to the choice of health care provider until after the exhaustion of the Benefit Review Conference process, which could only occur after the treatment (by the health care provider whose right to treat was contested) was concluded by reaching MMI.

This process of handling disputes in Tennessee differs from predominant models used in other states. Although no two state workers' compensation systems are alike, in general, the state government agency charged with overseeing workers' compensation is given authority to hear and resolve disputes. There are two major models for this sort of system. In one, the statutory workers' compensation agency runs a specialized "court" which hears formal disputes. The court employs "hearing officers" or Workers' Compensation Judges ("WCJs," sometimes also referred to as "ALJs" or "hearing officers"), who conduct hearings, take evidence and issue opinions. These opinions have the force of law, but are subject to appeal on issues of law to the appellate courts of the State.

The other major model is based upon a "Board" or a "Commission" charged with the resolution of disputes and administration of the law. Additionally, Boards and Commissions sometimes are charged with general administration of the workers' compensation program. Decisions of Boards or Commissions are typically appealed to court of appeals or a state supreme court.

There are a few states that assign the adjudication of workers' compensation disputes to a separate agency of the executive branch that holds administrative law hearings. The workers' compensation agency may still try to mediate disputes, but loses control once referred to the outside agency. Relevant examples of these various models are provided in the Appendix.

There are few other states that allow the civil trial courts, or special branches of the court system to hear and decide workers' compensation cases. These courts are under the supervision of the state Supreme Court.[31]

[31] In each of these models, the name of the official who presides over the dispute varies. Some examples of these officials include: West Virginia ("Judge"); Florida ("Judge of Compensation Claims"); Georgia ("Administrative Law Judge"); California ("Compensation Judge"); Pennsylvania ("Judge," but also referred to as "Referee"); Louisiana ("Workers' Compensation Judge"); Virginia ("Deputy Commissioner"); New

Thus, Tennessee's system is unique in the following key aspects:

- The workers' compensation administrative agency is not authorized to issue "final" decisions.
- An employer must pay benefits, in the face of a dispute of compensability, until the injured worker reaches maximum medical improvement, which can take many months, or even years.
- Courts of general jurisdiction hear workers' compensation cases, but only after an administrative process is "exhausted"; however, much of the determinations of the process are inadmissible in the court proceeding.
- With a few exceptions, trials in circuit and chancery court are relatively few, which means that judges are required to apply complex workers' compensation laws only infrequently.
- Consistency of application of the workers' compensation law is subject to a judicial process that is highly distributed across the state, subject to varying interpretations, without a "central" review panel until review by the Tennessee Supreme Court's Special Workers' Compensation Appeals Panel.

It has not been clearly established how these features affect system costs. There is some evidence that in the 1999-2000 period attorney involvement was relatively high in Tennessee claims, including high defense cost involvement.[32] Information from NCCI shows that, among several neighboring states, Tennessee defense and cost containment expense (DCCE) as a percentage of incurred losses in 2011 was at the median, and approximately 5% above the average of the states. The NCCI information also indicated that DCCE costs have generally increased over the past 10 years.

It is accepted that judicial interpretations, however, vary across the state.[33] There have been several reform efforts in Tennessee since at least 1994 to address this issue. Moreover, varying judicial approaches, as shown by the disparate incidence of trials, are inefficient and likely lead to inconsistent results. Final adjudication of issues sometimes requires working through a lengthy administrative process before civil trial, causing unnecessary delays in issue resolution. For these reasons, and to provide for clearer administration of Tennessee's workers' compensation program, basic structural reform is in order.

York ("Workers' Compensation Law Judge"); Colorado ("Administrative Law Judge"); Arkansas ("Administrative Law Judge"); Connecticut ("Commissioner").

[32] Victor, R., "Measuring the Complexity of the Workers' Compensation Dispute Resolution Processes in Tennessee." WCRI, Apr. 2004, FR-04-02, Cambridge, Mass.

[33] This variability was shown, with respect to permanent partial impairment ratings, in a study by WCRI requested by the Tennessee Advisory Council on Workers' Compensation. See Boden, L., "Permanent Partial Disability in Tennessee: Similar Benefits for Similar Injuries?" WCRI WC-97-5, Dec. 1997, Cambridge, Mass.

Recommendations

In summary, we recommend the following elements to transform the Tennessee system to one of administrative justice:

- Repeal the grant of original jurisdiction to circuit or chancery courts.
- Create a mandatory alternative dispute resolution mechanism for the presentation of disputes, resolution of disputes by agreement or recommendation, and narrowing of issues for formal dispute resolution ("mediation").[34]
- Eliminate different dispute categories (RFA and BRC) in favor of a single "complaint for benefit determination" which will be used for all categories of dispute.[35]
- Utilize the same procedures for dispute resolution for all categories of disputes, provided that some specified procedures like UR, PPD formula reviews, or other similar issues that might be part of a unique or "rocket docket" type of process.
- Establish an administrative proceeding housed within the Division, staffed by Workers' Compensation Judges, and binding, if not appealed, on all matters of fact and law.
- Establish the position of "Chief Judge," appointed by the Division Administrator, to manage the Workers' Compensation Judges.
- Provide the right to appeal to a single venue within the Division for Administrative Review of matters, prior to further appeal.
- Continue use of Special Workers' Compensation Panel for further appeal and permissive review by the Supreme Court.

Moreover, as will be addressed in another section of this report, Tennessee should create an Ombudsman program that provides a mechanism for avoidance of disputes that can be resolved by facilitating communications, educating parties as to their rights and obligations and facilitating resolutions outside the legal process. Together with the mandatory mediation program, these processes will result in the avoidance of disputes and will reduce the incidence of hearings.

An additional recommendation that would lead to greater efficiency would be to institute an electronic filing program. This could range from more simple online submission of case pleadings and documents to a more robust electronic dispute

[34] In Arkansas, the "Ombudsman" and "mediation" functions are combined. The resolution rates show that over 90% of claims are resolved before formal hearing. During the latest reported three-year period, the resolution rate before formal hearing was 90.5% (2009), 91.7% (2010) and 92.1% (2011). There are, however, relatively few mediations conducted; in 2009 there were 75 conduced, in 2010 there were 41, and in 2011 there were 91. This reflects the effectiveness of the ombudsman component of their services, and also reflects the additional potential for avoidance of litigation in the creation of a separate mediation function, as we have recommended.

[35] Hearings would cover all workers' compensation issues, such as compensability, disability, treatment, return-to-work, impairment, payment, penalties, and enforcement actions, such as for failure to insure.

management system. Federal courts have long since moved to these methods, and state workers' compensation programs have followed suit and begun moving to electronic filing. This allows for more efficient and timely processing of cases, allows litigants to have real-time access to documents, and provides the Division with better data tracking and performance management tools.[36]

Implementation

To implement these changes, we recommend the following:

- Authorize appointment of "Workers' Compensation Judges" (WCJ) to decide cases and review decisions. Suggest a nominating commission, similar to that used in the judicial nomination process, from which the Division Administrator can select and make an appointment for a term of years; we suggest six-year terms.
- Adjust the manner by which the Division Administrator is appointed:
    - Direct appointment by Governor for six-year term from list of candidates.
    - Submission of at least two qualified candidates from Selection Committee; Governor must select from list (similar to the judicial nominating process).
    - Selection Committee headed by Commissioner of Labor and Workforce Development; Committee must take input from representatives of the business and labor communities.
    - Governor may remove Division Administrator for non-performance of duties; replacement for balance of suspended term follows the same appointment process; until replaced, interim Division Administrator shall be selected by Governor from among existing members of Division Administrative Review Panel or WCJs.

The details that would be involved in implementing these recommendations are presented in the Appendix. In general, the dispute resolution process would involve:

- Division Mediators would facilitate mandatory mediation of all disputes;
- Outcome of mediation would be "Dispute Certification" issued by Mediator; if no further issues, this would serve as documentation of agreement. Dispute Certification would outline issues in dispute for WCJ resolution.
- Sanctions would be available for non-compliance with informal dispute resolution processes.

[36] Tennessee has adopted the Uniform Electronic Transactions Act, Tenn. Code 47-10-101 et seq., and this section applies to government transactions. To ensure acceptance by stakeholders, however, it is recommended that a section be added to the Workers' Compensation Laws that specifically allows the Division to approve electronic methods for the exchange of documents, records, and other information. *See, e.g.*, Va. Code 65.2-101 ("filed" includes any "means of electronic transmission approved by the Commission.")

- WCJs would conduct hearings on certified issues, pursuant to rules adopted by the Division.
- WCJs would take evidence, hears witnesses and motions, and issue findings of fact and conclusions of law.
- WCJs would conduct "rocket docket" for issues certified by the Director as appropriate for quick resolution.
- Findings of fact and conclusions of law would be subject to review by the Division Administrator. The Division Administrator would designate a panel of reviewers, and one would be randomly assigned to conduct the review. The standard of review is to ensure that the findings are not are arbitrary or capricious or against the clear weight of the evidence; this is a summary review that should be completed within 7 days.
- Appeal of right only on matters of law to the Special Workers' Compensation Appeals Panel.
- Further appeal at discretion of Tennessee Supreme Court.

Staffing Impact

We have analyzed staffing levels and current capacities and compared these with estimated requirements as a result of these changes. Based on this analysis, we estimate that the Division would need 20-21 Workers' Compensation Judges and 7-8 support staff, in addition to court reporting or transcription and foreign language interpreters.[37] The current Division Benefit Review Specialist, Level 4 position would be fairly equivalent to the WCJ. There are 17 such positions filled at the Division. The comparison is not perfect, as the WCJ role will involve considerably more pre-hearing activity of an administrative nature than is performed currently at the Division, and also requires different skill and experience.[38] To supervise this activity, the role of "Chief Judge" would be created. An additional support staff for the Chief Judge role would be needed.

For pre-hearing mediation activities, the Division would need 30-31 Mediators and 10-11 support staff. The current Division Benefit Review Specialist Level 2/3 is the most comparable position to the "Mediator" position. We estimate that 3-4 additional positions are needed, in addition to 1-2 more support staff. The Mediator position would be critical to reducing the incidence of trials. This would result in a total staff complement of 30-31 specialists and 10-11 support staff.

[37] We recommend contracting for these services until volumes level off and are predictable.

[38] For comparison purposes, current filled positions for hearing officers in a sample of states are: Virginia has 21 hearing officers, Kentucky has 25, Arkansas has 10, Missouri has 30, Minnesota has 21, and Arizona has 19. Note that the scope of duties and inclusion of supervisors in the count varies by state.

In summary, we would estimate an increase of approximately 11-13 individuals over current levels, specifically: 1 Chief Judge, 1 Chief Judge support staff, 3-4 Specialist 4s, 3-4 Specialist 2/3s, and 3 Specialist Administrative Support staff.

A related reform is for the Ombudsman program, which we estimate would eventually grow to one trained Ombudsman in each of the 7 regional offices, 3 in the main office, 1 supervisor, and 1 support staff, plus 5 staff members (as currently staffed) to handle current call volumes. We recommend adding 3 Ombudsmen (1 with part-time supervisory duties), and 1 support staff, in addition to keeping the 5 Help-Line staff, at the initiation of this new program.

It is extremely important to note that both hearing and pre-hearing activities will involve a higher degree of Division involvement, expertise, and activity than is used today for dispute handling. This is particularly true of the informational and alternative dispute resolution functions. If done well, as in other successful states, the Ombudsman and mediation programs can substantially limit formal hearings.

In summary, quick resolutions of disputes allow the parties the greatest chance to avoid the complexities, cost, and indirect harm to employers and claimants and relationships caused by litigation. The use of alternative dispute resolution (ADR) mechanisms are proven elsewhere and can be projected to apply as well in Tennessee. ADR will reduce the average time in dispute; reduce the average cost of loss adjustment cost per claim; increase predictability of results; and reduce unintended subsequent harm to injured workers caused by the delays and stresses over litigation. Additional modifications to the formal dispute resolution process are based on providing final resolution from a qualified, experienced adjudicator according to tailored rules and procedures.

Expected Outcomes

Thus, these reforms should accomplish the following:

- Greater consistency in application of the workers' compensation law.
- Reduction of the percentage of claims requiring formal adjudication.
- Adjudication that is not tied to exhaustion of administrative remedies or to achievement of MMI.
- Quicker resolution times for compensability disputes.
- Elimination of impact on second injury fund from "improperly paid benefits."
- Better service to pro se claimants (as opposed to a pro se claimant having to go to circuit court).
- Reduction of the percentage of claims in which the parties need attorney representation.

Lower overall attorney involvement should be achieved through other reforms, such as reforming the multiplier process; reducing disputes over medical treatment; and streamlining the impairment rating process. Moreover, ombudsman and mediation practices should also lower the need for attorney involvement. Based on recent research, it is estimated that this will be achieved in three ways:

1. Provision of education and informal dispute avoidance procedures in the Ombudsman program could resolve between 70% and 85% of matters brought to the program (Attorneys will not generally be utilized in these resolutions).
2. Mandatory mediations might well achieve an approximate 66.67% resolution rate due to mediation (and perhaps higher numbers) prior to trial (Attorney representation is optional in these proceedings, but it is expected that more often than not parties will have attorney representatives).
3. More predictability and better established jurisprudence in the system will reduce the attraction of "rolling the dice" to see what happens in court, and attorneys will advise their clients when pursuit of a remedy in adjudication is unlikely to be economically beneficial.

In measuring success of this program, the Division should continue to track case volumes and durations of questions and disputes, but also collect more granular information about issue types and specific outcomes. Moreover, for management purposes, information should be tracked at the WCJ and mediator level. Benchmarks, based on current loads, should be set and measured against, as well as adjusted over time. The Division should expect a spike in activity immediately following implementation of the reforms, as the law takes effect and the boundaries are tested, but should establish target benchmarks 1 to 2 years post implementation as this activity levels off.

Report on Streamlining Permanent Disability Compensation

Issue

The method of awarding Permanent Partial Disability (PPD) Benefits has become a central complaint by employers and insurers in Tennessee. The so-called "multipliers" are a unique feature of Tennessee workers' compensation law. A multiplier is the multiple by which a judge can raise an award for PPD, over and above the award based strictly on the impairment rating. The award is designed to compensate an injured worker for "disability partial in character but adjudged to be permanent." The PPD award can be adjusted upward based on evaluation of several factors, such as age, education, and training. But ultimately the maximum award ranges from one to six times the amount based strictly on the impairment rating.

In the 2004 Tennessee law changes, the maximum PPD multiplier for claimants with certain injuries that return to work with their previous employer was reduced from 2.5 to 1.5. This incremental modification was estimated to be responsible for a 5.4% reduction in system cost, by far the biggest effect of the 2004 reforms on indemnity cost.[39]

In analyzing the motivation behind the 2004 reform of PPD, WCRI states:

> Before the reforms, the average indemnity benefit in Tennessee was significantly higher than in the typical study state—largely because the average PPD and lump-sum payments per claim were much higher than typical. Tennessee had the highest average PPD/lump-sum payment per PPD/lump sum claim-- $31,302 compared to $13,368 for the median of non-wage loss states…even compared to the second highest state in the ranking—North Carolina—with Tennessee 30 percent higher than North Carolina… [40]

In addition to adding to employers' costs, determination of the final PPD multiplier to be applied to an individual case results in delays in payment of permanent disability benefits to injured workers.

Injured workers have much to gain from a reformed PPD system. Foremost in gains is the speed of payment. WCRI found average delays from the last TTD to first PPD payment was very long. Even for claimants that returned to work the delay was 9 to 18 months.[41] There is no reason PPD payment should not begin immediately after MMI. A self-executing system for benefit determination would eliminate the need for attorney involvement in securing accurate payment. Finally, for the risk-adverse claimant, getting a highly predictable award is better than the chancy outcomes of the "multiplier game."

Currently, the possibility of stretching in situations in which the claimant has not returned to work, a multiplier of up to 6 times the PPD indemnity from the impairment rating may be determined by a judge. This may be perceived by the claimant as a chance of a big payout, and creates a great disincentive to return to work. Unnecessary delays in return to work may be disastrous to the long-term earnings of the claimant.

Background

[39] NCCI, "Post-Reform Study, House Bill 3531. Provisions Effective July 1, 2004," May, 2010, Boca Raton, Florida.
[40] Radeva, E. and Telles, C. "The Impact of the 2004 PPD Reforms in Tennessee: Early Evidence," p. 2, WCRI FR-08-02, May 2008, Cambridge, Mass.
[41] *Id.*, p 7. The delay estimates were found to depend on the development period being used for analysis.

Every state has struggled to come up with a model for compensating permanent injury that is fair, efficient, and reduces litigation. Yet, despite a century of experimentation, no single model has emerged as the dominant system for awarding indemnity benefits for injuries deemed to be permanent. Why such diversity? The root cause seems to be that quantifying the future employment and earnings is extremely difficult. The same injury can produce radically different outcomes for different people.[42] Despite the best efforts to come up with predictive factors, no state has devised a formula that comes close to predicting earnings loss for purposes of awarding PPD.[43] We will discuss the various state approaches, a favored approach, and some specific adjustment factors to PPD for earning capacity loss.

The unique Tennessee system for determination of PPD benefits involves a two-step process. First, an impairment rating and assignment of weeks of PPD pursuant to the schedule in Tenn. Code 50-6-207 is assigned. Second, there is a judgment on the degree of earnings loss based on a rather open ended set of criteria and court judgment. The idiosyncratic nature of this feature of Tennessee law is a point of criticism by multi-state employers. A listing of states and their basic approach to PPD benefits is attached in the Appendix to this section.

Tennessee, like 22 other states, uses a version of the AMA *Guides to the Evaluation of Permanent Impairment* as the starting point for calculating permanent impairment benefits for all permanency claims. Fifteen states use vocational factors to supplement the impairment rating in fixing the amount of PPD benefit. Ten of these states restrict the factors to a portion of claims: Arkansas, Colorado, Iowa, Kansas, Maryland, Montana, New Mexico, Oregon, Wisconsin, and Wyoming. Return to work affects PPD rating in the following states: (all claims) Florida, Montana, New Mexico, and Tennessee; (some claims) Arkansas and Wisconsin. Please see Appendix V. for more details.

In making PPD determinations, Tennessee law requires the circuit court to "consider all pertinent facts," which may include lay and expert testimony, the employee's age, education, skills and training, local job opportunities (measured by the unemployment rate) and capacity to work at types of employment suitable to the claimant's disability. Tenn. Code Ann. 50-6-241(a)(1). Even if a judge happened to have a background in

[42] This was shown in a study by WCRI requested by the Advisory Council. See Boden, L., "Permanent Partial Disability in Tennessee: Similar Benefits for Similar Injuries?" WCRI WC-97-5, Dec. 1997, Cambridge, Mass.

[43] California is probably the state with the longest and best research agenda to quantify loss of earning capacity as a function of relevant vocational factors. In 1996, the California Commission on Health and Safety and Workers' Compensation commissioned the RAND Corporation to begin an extensive review of PPD benefits. That research shows that the California system gives indemnity benefits for permanent injuries that are proportionate to earning loss. However, the research uncovered many flaws in the estimating loss of earnings capacity. See: Robert T. Reville, Seth A. Seabury, Frank W. Neuhauser, John F. Burton and Michael D. Greenberg, "An Evaluation of California's Permanent Disability Rating System." Santa Monica, CA: RAND Corporation, 2005, available at http://www.rand.org/pubs/monographs/MG25.

vocational skills and job placement, it would be difficult to accurately project future earning losses for each particular claimant.

In reality, the problem of subjectivity is made worse by the varying backgrounds and expertise of the judges who set the precedent for awards in each county. In turn, the tendencies of the judges in a county set the standard for negotiated settlements. Beside subjectivity and inconsistency, the court process adds needless delay in reaching a final benefit determination. Depending on the issues in dispute and the trial and appellate process, litigation over disputed awards can take months or even years to be finalized. Finally, the court process means attorney involvement and a reduction in net indemnity received by the claimant due to legal fees.

Besides dissatisfaction with litigation, some employers object to paying any multiple of the permanent impairment award if the worker returns to work at their pre-injury wage. Their reasoning is that the PPD formula for impairment should be adequate and fair without the multiplier, especially if there is no evidence of earnings loss.[44] Some even argue that there should be no PPD award at all if there is full employment recovery after MMI. Such is the policy of seventeen states that use the pure "wage loss" principle of indemnity.[45]

Worker advocates focus on the adequacy and speed of PPD payments. In Tennessee, as in most states, the relationship of PPD benefits to long-term earning capacity loss has never been studied and so is undetermined. Most experts would agree that even minor permanent injuries are likely to hamper long-term career potential for some classes of workers, e.g. construction trades. There is mounting evidence that long spells away from work are likely to produce large future earnings losses.[46] Moreover, in determining

[44] Yet, the current impairment rated weeks were never contemplated to be the full and final payment for permanent injury; some multiple was expected. Thus, if one wanted cost neutrality as a policy goal, the impairment benefits would have to be increased for those who returned to work. Put another way, the current impairment benefits would have to be scaled up by the average multiplier for those who return to work.

[45] Wage loss states employ the following approach: if the claimant returns to work at wages that are equal to or greater than the average weekly wage, no workers' compensation indemnity is due for permanent injury. If the claimant has no subsequent wages, or reduced wages, then the claimant gets two-thirds of the average weekly wage subject to a maximum length of time or for the length of wage loss. Within this model there are many variations.

[46] See: J. Crooke et al., The Probability of Recovery and Return to Work from Work Disability as a Function of Time," *Quality of Life Research,* Vol. 3, Supplement: Chronic Pain (Dec., 1994), pp. S97-S109; Robert T. Reville, Suzanne Polich, Seth A. Seabury and Elizabeth Giddens, "Permanent Disability at Private, Self-Insured Firms: A Study of Earnings Loss, Replacement, and Return to Work for Workers' Compensation Claimants," RAND Corp, 2001 Santa Monica, Cal., available at http://www.rand.org/pubs/monograph_reports/MR1268; Robert T. Reville, Seth A. Seabury, Frank W. Neuhauser, John F. Burton and Michael D. Greenberg, "An Evaluation of California's Permanent Disability Rating System," RAND Corp, 2005, Santa Monica, Cal., found 2012 at: http://www.rand.org/pubs/monographs/MG25; and Jeff E. Biddle, Leslie I. Boden and Robert T. Reville, "Permanent Partial Disability from Occupational Injuries: Earnings Losses and

the vocational impacts of injury, duration of time away from work is a powerful predictor of permanent disability.[47] Studies differ, but once an injured worker has experienced a spell of time away from work greater than a year, the likelihood of return to work becomes considerably diminished, with odds as low as one chance in three of ever returning to work.

The structure of PPD determination will affect financial incentives for the injured worker. It may motivate some claimants, usually under advice of counsel, to build a strong medical treatment record to bolster the case for large impairment. It may also motivate employees to magnify their inability to work in order to obtain a larger multiplier on the impairment rating.

Loss experience from the NCCI shows that PPD is a very significant part of total indemnity benefits paid and would be highly sensitive to alterations in the multipliers or replacement with a new system. In addition to loss cost savings, it is likely that a simplification of PPD determination would reduce litigation, which would save on court costs and attorney fees. A more objective formula would speed benefits to injured workers and reduce their need to hire attorneys to ensure a fair payment. It would also place Tennessee more in line with neighboring states in the basic approach to permanent disability benefits.

The question we ask is this: would it be better to have a single formula for computing the benefit based on vocational principles, or to have many county judges offering many differing solutions to the issue? If individual equity, i.e., better wage replacement, could be assured, then the judicial approach might have merit. But, equity seems doubtful if a ruling depends on the venue in which a dispute is filed, or the judge offering his or her opinion.[48] We favor the principles used by 15 states, which quantify the PPD benefit based on the impairment rating and a select list of vocational factors. (see Appendix V.)

Recommendations

We are recommending a complete overhaul of the PPD benefit system. Tennessee needs a much simpler and more objective way to assign PPD benefits. Doing so will produce a faster, more efficient and self-executing administration of the law. If properly devised, the benefits will more consistently match the loss of earnings capacity for which PPD was intended to compensate.

Replacement in Three States," RAND Corp, 2001, Santa Monica, Cal., found 2012 at: http://www.rand.org/ pubs/ reprints/RP939.

[47] Phil S. Borba and Mike Helvacian, "Factors That Influence the Amount and Probability of Permanent Partial Disability Benefits," WCRI, June 2006. WC-06-16, Cambridge, Mass.

[48] See WCRI, Boden, *supra*, regarding variability of awards.

For workers that return to work with any employer earning 80% or more of their pre-injury wage, the following steps are recommended:

1. Assign reliable measures of permanent impairment.[49]
2. Determine the weeks of payment from the percentage of whole body impairment in the rating.
3. If the injured worker returns to work, for any employer, earning 80% or more of their pre-injury wage, that claimant receives a periodic payment equal to their TTD rate times the number of weeks determined by the current impairment rating system.
4. The maximum total weeks of permanent compensation that can be awarded is increased to the number of weeks necessary to make the reformed PPD system cost equivalent to the aggregate payments for PPD under the current system (this is a policy judgment that can be modified according to other priorities).
5. PPD benefits payable in #3 above are offset by the weeks of TTD beyond the date at which MMI was established (often MMI is in dispute and TTD may continue, so the offset would apply to TTD "overpayment" beyond MMI).
6. If the employee involuntarily loses work during the period of weeks allowed for permanent impairment benefits, he or she can petition the Division for reconsideration of benefits under the formula for job loss, described below.

> Example: 25% impairment rating yields 100 weeks of "impairment only based" PPD. If claimant goes back to work at MMI, TTD ends and PPD begins to be paid. If during the 100 weeks the employee losses the job involuntarily, then by petition to the Division, the claimant can have the original benefit recalculated as if it were a non-RTW case. There would be an offset for the PPD weeks already paid.

For workers that have <u>not</u> returned to employment earning 80% or more of their pre-injury wage at the time of MMI, the following steps are recommended:

1. Assign reliable measures of permanent impairment.
2. Determine the weeks of payment from the percentage of whole body impairment in the rating.
3. At this point PPD determination switches to a formula driven by vocational factors.[50] The specific parameters used here are only reasonable starting points for the sake of discussion. The final determination of the parameters should be based upon actuarial cost estimates and public policy considerations. So, for

[49] Accurate and consistent ratings are essential to the fair administration of assigning PPD benefits. There is a companion piece in this overall study that addresses the issue of impairment ratings. It contains recommendations that should improve the accuracy and consistency of ratings.

[50] In selecting these factors we choose those that can be adjudicated with reasonably objective data from reliable sources. We rejected several commonly used factors, such as the age of the claimant, because they do not reliably predict loss of earnings with extensive complication to the formula.

purposes of illustration, assume that the impairment rating weeks would be increased by the following adjustment factors:

a. Base adjustment for physical exertion[51] on the job. If a worker, at the time of the injury, was performing heavy labor activity and after the injury the worker can perform only light or sedentary labor activity, 30%, or "1.3x"; if a worker, at the time of injury, was performing heavy labor activity and after the injury the worker can perform only medium labor activity, 20% or "1.2x"; if a worker was performing medium labor activity at the time of the injury and after the injury the worker can perform only light or sedentary labor activity, 10%, or "1.1x." If there is no change in the degree of activity that can be performed after the injury as compared with what the worker was performing before the injury, then the base adjustment is "1x."

b. Education adjustment. For a worker who has completed fewer than 12 years of education, 25%; for a worker who has completed 12 years or more of education or who has received a graduate equivalency diploma, 0%.

    Example: If the base adjustment is 1.3x, then an educational adjustment of 25% would result in a total multiple of 1.625x.

    Rationale: This seeks to recognize that injured workers with less education will have more difficulty finding employment.

c. Unemployment adjustment. If at the time of the MMI injury, the unemployment rate in the county of pre-injury employment working for the employer at a location in a county where the unemployment rate is greater than 12%, based on guidelines adopted by the Division in accordance with the Tennessee Employment Commission), then 15% will be added; if the unemployment rate is greater than 9% but less than 12%, then 10% will be added.

    Example: The 1.625x multiple above, adding 20% for unemployment, would result in a total multiple of 1.95x.

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[51] As used in this section the physical demands of a job are classified according to the Social Security Administration's Physical Exertion Requirements in § 404.1567, summarized below:
Disability definitions:
(a) "heavy labor activity" means the ability to lift over 50 pounds occasionally or up to 50 pounds frequently;
(b) "medium labor activity" means the ability to lift up to 50 pounds occasionally or up to 25 pounds frequently;
(c) "light labor activity" means the ability to lift up to 20 pounds occasionally or up to 10 pounds frequently; and
(d) "sedentary labor activity" means lifting no more than 10 pounds at a time and occasionally lifting and carrying articles like, docket files, ledgers, and small tools; also involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties.

Rationale: This seeks to recognize that injured workers employed in locations with higher rates of unemployment will have greater difficulty finding gainful employment.

The employee will draw PPD based only on impairment rating until benefits are exhausted. At that time benefits will be extended only for those workers who have not returned to work earning at least 80% their pre-injury wage. This will be done by the above formula to rule out subjective interpretation, or the need for vocational expert testimony.

The insurer should have the right to petition for suspension of the payment of this extension of PPD weeks based on documentation that the employee is qualified for jobs that are available in the local economy. If at the end of this additional "safety net" payment, the worker is still not employed, they may petition for permanent total benefits.

Lump sum settlements, instead of periodic payout of the weeks of PPD, should be avoided if the injured worker has not returned to work.[52] We base this on concern over the tendency for some claimants to dissipate a large lump sum that is the only family cash support for an unforeseen number of years.

Report on Temporary Total Duration Limits

Issue

Across the country, indemnity for temporary total disability (TTD) tends to be more similar than most other features of workers' compensation law. Tennessee's TTD indemnity benefits and procedures are fairly mainstream. The issues here are focused on delays in the declaration of MMI, and the poor incentives created by the law to resist declaration of MMI and return to work.

Background

[52] Admittedly, opinions and evidence on the merits of allowing lump sum settlements vary.

According to WCRI Compscope™ data, Tennessee had an average TTD indemnity payment per claim that was below the 16 state median for both accident years 2006 and 2008. The difference was much greater in the older accident years.[53]

The average duration of TTD in Tennessee was either slightly greater or less than than the median in the 16 state Compscope™ sample, depending on the measurement year chosen.[54] Moreover, Tennessee was remarkably close to the 16 state central tendencies for every duration time interval, e.g., less than 2 weeks, less than 4 weeks, etc.

TTD rates are two-thirds of an employee's gross average weekly wage (AWW), up to a maximum of 110% of the state's average weekly wage, which is currently $886.60. Thus, the maximum TTD rate is $591.07 per week. Thirty-eight states pay TTD at the two-thirds AWW rate; three are higher (pay 70-75% of AWW); two are lower (pay 60% of AWW); and the rest are based on after-tax earnings (75-80%).[55]

Tennessee currently pays TTD for the duration of disability. Claims relating to "mental injury" are capped at 104 weeks after MMI, and certain pain management claims are capped at 104 weeks after either MMI or the commencement of pain management treatment.

In practice, there is a cap of sorts on other claims, as the maximum TTD allowed, once MMI is reached and an impairment rating is given, is 60 days. Tenn. Code 50-6-234. Theoretically, this should mirror duration of disability. Disputes about MMI and impairment ratings, however, can serve to extend this period. For example, if the employer argues that MMI has been reached and a proper impairment rating given, but the employee disagrees, and a Division Workers' Compensation Specialist agrees with the employee, then TTD continues until the MMI pre-condition is satisfied.

Capping total weeks of TTD is practiced in one way or another by 20 states, with the rest providing benefits for the length of disability. NCCI input shows that there is a long tail on the distribution of TTD duration, i.e., 10-20 percent of injured workers take several times longer to end benefits than the median duration of TTD. Yet, unless benefits were capped at the lowest extreme of states with caps (around 104 weeks) the effect on overall system costs would be very small. We note that capping TTD benefits puts workers with extremely serious injuries at a disadvantage because their TTD benefits may expire but PPD benefits may not be available until they reach MMI.

Recommendations

[53] Radeva, E. et al., "Compscope Benchmarks for Tennessee, 11th Ed.," WCRI, WC-11-13, Jan. 2011, Cambridge, Mass.
[54] *Id.* at p. 77.
[55] "2012 Analysis of Workers' Compensation Laws," pp. 49-60 (U.S. Chamber of Commerce).

We recommend three incremental changes to the rules for TTD benefits:

1. Maximum medical improvement should be deemed to have occurred when the treating physician ends treatment and the only remaining active medical care is for pain management. This modifies the current provision for pain management treatment, and instead of capping TTD at 104 weeks after beginning pain management treatment, it caps it immediately after all other treatment besides pain management treatment ends.

   The rationale for this is that if pain management is a desirable for the injured worker, then ethically it might be required to be offered by the treating physician. In the same spirit, it is medically appropriate to use pain management specialists for chronic pain that is beyond the professional qualifications of the treating physician to control. Regardless, at a minimum, pain management treatment is a source of controversy in the return of workers to gainful employment, and economic issues should not overly influence behavior with respect to returning injured workers to health and employment. Thus, because there should be no economic incentive to continue pain management beyond the point at which medicine cannot further cure the underlying injury, this recommendation seeks to remove such incentives.

2. If TTD is paid while there is a dispute over the deemed MMI date, any TTD paid after the final fixed date of MMI will be applied to offset PPD payments.

3. Continue the cap of 60 days as in Tenn. Code 50-6-234, but base it solely on MMI, as determined by the panel treating physician, without regard to whether an impairment rating had been made. This would be accompanied by a rebuttable presumption that the panel treating physician's opinion on this issue is correct. A related reform, covered elsewhere, is to improve the impairment rating process, which would provide a much more straightforward process which will diminish disputes over that issue.

Expected Outcomes

This recommendation accomplishes the following:

- It maintains stability in the system with respect to outcomes that track fairly consistently with common national patterns.
- It helps incentivize return to work.
- It cuts down on friction and lost adjustment time dealing with resistance to declaring MMI even after healing from the injury has plateaued.
- It helps prevent disputes over MMI and impairment ratings.

Improving the Tennessee Medical Fee Schedule

Issue

Evidence from WCRI and NCCI suggests that Tennessee's medical fee schedule has been an effective tool in reducing the inflation in medical claim costs, which plagues most state workers' compensation systems. After the implementation of the Tennessee fee schedule in 2005, medical cost per lost time claim in Tennessee went down. According to WCRI data, Tennessee moved from being an above median to below median state in terms of medical cost per claim.

Despite the improvement in per claim medical cost in Tennessee, certain incentives need to be corrected so that fees can work in harmony with other cost containment measures. The current form of the fee schedule sets distorted incentives for medical care, and does not offer real control on in-patient hospital costs. More will be said below about these issues.

Setting a correct fee schedule amount involves a delicate balancing act between the objectives of cost control, incentivizing good occupational medicine providers, and discouraging overutilization of risky or unorthodox treatments. These recommendations are based on accomplishing reform, taking into consideration the interaction of various proposals on the overall system.

Background

All but seven states have medical fee schedules for payments to one or more type of medical provider. According to the 2012 WCRI benchmarking report on fee schedules[56] for professional services, which ranks state schedules against Medicare payment levels (for professional services only), Tennessee was ranked 9th from the top in the percentage of its payment over Medicare. Tennessee's schedule was more generous, relative to Medicare, than most states in the southeast region, as shown in the following table. It is important to note that this comparison was done before the downward revision of the income conversion factor in the Tennessee schedule, effective August 2012. Without redoing the WCRI comparison for all states, we can only speculate that the relatively high payer ranking for Tennessee might remain unchanged.

[56] Fomenko, O. and Liu, T., "Designing Workers' Compensation Medical Fee Schedules," WCRI, WC-12-19, June 2012, Cambridge, Mass.

State	Premium % Overall Compared to Medicare
Alabama	64
Arkansas	56
Florida	2
Georgia	71
Kentucky	34
Louisiana	48
Mississippi	58
North Carolina	11
South Carolina	44
Tennessee	83
Texas	65
West Virginia	39

Source: WCRI, *Id.*, Table 3

A more concrete look at the relative fee maximums for Tennessee compared to neighboring states is shown below. From this perspective, Tennessee is more in line with neighboring states for this single example of radiologic exam, second most generous for office visit, and third most generous for shoulder arthroscopy. It is also interesting to note that some states are substantially below the Tennessee maximum (again before the August 2012 downward revisions).

State	Office Visit (established patient) (code 99213)	Radiologic Exam (code 73030)	Arthroscopy of the shoulder (code 29826)
AL	$62	$39	$2738
AR	93	21	1388
KY	78	15	1209
GA	102	25	2080
MS	79	15	1606
NC	126	21	1608
TN	119	21	1909

Source: WCRI, *Id.*, Table 5

Across the US health care system, fee schedules are a common cost control mechanism and defense against cost shifting. Most major payers of medical bills outside of workers' compensation employ some sort of schedule to control maximum payments. If workers' compensation systems were to force payers to submit to "usual and customary" charges by providers, their costs would be much higher. The few states without workers' compensation fee schedules tend to have much higher medical costs.

Naturally, medical providers seek to be paid at the rate they feel is justified by their skill and market factors. Some doctors with much higher than average charges are very accomplished specialists, who feel that their fees are justified by their specialized equipment, skills, and success rates. Other doctors serving low income communities or in low cost practice settings might have standard charges that are much lower than other doctors. Thus, there is a very wide distribution of charges among doctors for a particular service or treatment. By design, fee schedules truncate payments somewhere between the middle and the high end of the charge distribution.

Hospitals, too, have vastly different charges. Each hospital can make a forceful case that its mission and cost structure are unique. Yet, Medicare is able to administer a workable fee schedule that adjusts its hospital compensation for individual hospital cost and mission characteristics.

Medical providers are typically opposed to locking payment schedules onto the Medicare methodology. It is generally admitted that Medicare does not pay doctors and hospitals their full cost of supplying services. Employers commonly allege that part of medical provider costs are shifted to other payers, like workers' compensation. A major element of provider objections to Medicare is the arbitrary and highly politicized system Congress uses to control the costs of Medicare by artificially suppressing payments to medical providers.

Access and Quality of Care

No state can limit charges to whatever extent it wishes in order to cut the cost of workers' compensation. The consequence of unreasonable fee limits is a withdrawal of services by a fraction of the provider pool, usually the high-end providers in specialty areas. It is a universal practice for physicians and their lobbyists to forecast doctor availability problems from fee schedules. So it is important to consider the experience on fee schedules and access to quality care.

Massachusetts has long held the position of the lowest paying fee schedule relative to Medicare as the benchmark. Yet, WCRI surveys of injured workers in Massachusetts consistently show little sign of access to care problems. Florida has been ranked by WCRI just above Massachusetts for years. Florida did have enough complaints about its low fees[57] to motivate an upward adjustment as part of major reforms in 2003. Yet, they are still second lowest in the nation. Texas has the purest form of a Medicare driven fee schedule. Except for some surgical procedures, Texas pays all providers 61% over what Medicare allows for a given CPT code in 2012. This is an increase from the 25% premium over Medicare initially in the Texas schedule for all types of physician services. The

[57] According to a series of worker surveys by WCRI, more Florida workers reported "big problems" obtaining care than workers in other states studied.

increase (2008) in the conversion factor and the creation of a second factor for some surgeries was due to provider complaints and threats of access-to-care problems. Knowledgeable sources in the Texas Division report no particular access problems since the fee reform. In Tennessee, the adoption of a fee schedule in 2005 seemed to have had a dramatic effect on prices paid and overall medical cost. But, according to WCRI's evaluation of post reform consequences, "…system participants indicated that there were no access to care problems for injured workers…"[58]

Cost Savings

WCRI specifically examined the changes in utilization and price per service in Tennessee before and after the implementation of the fee schedule in 2004. For non-hospital services, price per service was mostly unchanged, but utilization of services accelerated relative to pre-fee schedule. For outpatient hospital services, price per service after 2004 dropped, as did utilization. Before the fee schedule, Tennessee had an average medical cost per claim that was 5% higher than the median of the 16 Compscope ™ states. After the fee schedule, Tennessee was 8% lower than the median of the Compscope ™ states.[59]

A 2010 report by NCCI evaluating the cost implications of the 2004 reforms shows that the adoption of fee schedules in July 2005 seems to have had the following effects:

- Average medical cost per claims seem to have had a slower growth in 2006 and 2007 than before the fee schedule was implemented.
- Average amount paid to physicians dropped in 2006-2008, with nearly a 9% drop in the year following implementation.
- The specific effect of the physician fee schedule was a 2.7% drop in total medical costs in the post reform period relative to the pre reform years.
- The ambulatory, surgical, and outpatient costs were reduced by 3.0% from pre-reform years.
- Hospital inpatient costs were virtually unchanged due to the fee schedule.

Why Medicare?

Fee schedules driven off Medicare rules are desirable for at least the following technical reasons:

[58] Radeva, E. et al., "Compscope Benchmarks for Tennessee, 11th Ed.," p. 15, WCRI, WC-11-13, Jan. 2011, Cambridge, Mass.
[59] *Id.* This is based on 36 months of development, before and after the fee schedule was implemented.

- Medicare coding and billing rules are well known and frequently updated via a rigorous and transparent process. The adoption of Medicare billing rules allows for better accuracy and consistency in paying for services.
- By referring to Medicare rules, the state does not have to update its own administrative rules for payment system changes made by Medicare. While many states adopt multiple income conversion factors to use with Medicare RBRVS, a single conversion factor is more appropriate. The RBRVS relative unit values are rigorously established with medical provider input. Offering a different income conversion factor for one class of treatments versus another distorts the purpose and basis of Medicare unit relativities. Seemingly arbitrary differences in how varying specialties are compensated are an issue that is more political than substantive.

Apart from the above technical considerations, Medicare payment rules are well understood by parties that review and pay medical bills. Medicare based payment rules and relativities increasingly are used by group health insurers in negotiating contracts with providers.[60] Finally, if Tennessee were to adopt a fee schedule that was more aligned to Medicare, insurers and larger employers would be well equipped to adapt to the change.

In the reforms of 2004, it was prudent for Tennessee to model much of its fee schedule after Medicare in order to achieve standardizing in business practices. Using a Medicare basis for allocating payment levels for different treatment service was supported in a 2007 analysis by NCCI.[61] Likewise, the Texas Labor Code recognizes the advantages of standardization:

> In developing fee guidelines, Labor Code §413.011 requires the commissioner to adopt health care reimbursement policies and guidelines that reflect the standardized reimbursement structures found in other health care delivery systems, using the most current methodologies, models, values, or weights used by the Centers for Medicare and Medicaid Services (CMS) in order achieve standardization.

Final Cautions

Fee schedules, by themselves, are no magic bullet to controlling medical costs. Florida and Texas have more restrictive fee schedules than Tennessee, yet their total medical cost per claim are roughly comparable to that of Tennessee. Other factors, such as the

[60] According to NCCI, "While, traditionally, GH insurers geared reimbursement to UCR charges, increasingly, GH insurers follow the Medicare RBRVS reimbursement." Found in John Robertson and Dan Corro, *Making Workers Compensation Medical Fee Schedules More Effective*, NCCI Research Brief, December 2007, Boca Raton, Florida.
[61] *Id.*

quality of provider networks, treatment guidelines, the market price of medical service, and the mix of claims affect average medical cost per claim. As NCCI research has shown, changing the fee schedule up or down will not have a proportionate effect on average fees paid. Nor is it easy to predict how a change in the fee schedule will alter payments to providers in different specialties. Much depends on market prices for medical services relative to the maximum fee schedule amount, and on the bargaining power preferred provider organizations.

Fee schedules need to work in harmony with other cost containment efforts and to promote the supply of high quality occupational medicine to injured workers. Thus, fees should provide the correct incentives to practice good occupational medicine, and remove incentives for treatments that do not conform to best medical practices.

Tennessee has five specific levels of income conversion factors applying to different physician practices. General medicine is compensated at 160% of Medicare, while the highest compensated category (orthopedic and neurosurgery) is set at 275% of Medicare. Anesthesiology is capped at $75.00/unit and pathology is 200% of Medicare. The relatively high compensation for major surgery compared to the "evaluation and management" tasks of medicine clearly offers high incentives for surgery relative to time spent managing the patient's disability and return to work.

As shown in the WCRI benchmarking reports, the relatively high premiums over Medicare for surgery are common in workers' compensation fee schedules. They are routinely characterized as political concessions, not related to relative cost. By design, the Medicare RBRVS methodology should compensate surgeons for their higher time and practice expense for treatments. In addition to recognizing the true relative cost of various treatments, it is quite important that compensation levels be adequate when adjusted for the extra obligations of occupational medicine.

Based on evidence from other states with lower fee schedule limits on payment, we judge that Tennessee has the ability to trade off a reduction in maximum fees for specialists for removal of extra time and trouble in treating workers' compensation patients. The recommendations in this report, if implemented properly, should cure many of the irritants and extra practices and expenses from the practice of occupational medicine. These special tasks include: managing chronic pain and opioid use, functional evaluations and return to work plans, impairment ratings, independent medical examinations, and depositions for trial. Such tasks should either be much less commonly required for primary care physicians, or more appropriately compensated by special treatment codes in the schedule.

Recommendations

Professional Services

We recommend that the state modify the physician fee schedule to set the maximum allowable payment at an appropriate premium above the Medicare payable amount, and index this amount so that future payments are not subject to the whims of the annual Medicare income conversion factor changes.

The existing fee schedule rule[62] would be modified as follows:

- There would be only one income conversion factor for all medical doctors.
- Present billing codes, modifiers and conversion factors for other professional services should remain unchanged. The initial values of the income conversion factor for medical doctors should be 60% over the Medicare income factor in the initial year of the schedule.
- The income conversion factors would be annually updated to reflect changes in the Medical Economic Index,[63] a weighted average of price changes for goods and services used to deliver physician medical services. The adjustment would be done by applying the annual percentage adjustment of the MEI to the previous year's conversion factors. The new factors would become effective January 1st of the next calendar year beyond the period of the MEI index used.[64]
- Special occupational medicine codes should be recognized for the following services vital to workers' compensation, but unknown in the Medicare system:
    - Drug Counseling and Patient Agreements.
    - Independent medical examination (already included in TN fee schedule).
    - Depositions (already included in TN fee schedule).
    - Impairment rating by a Division certified rater.
    - Functional evaluation and return to work plan.

Appropriate descriptions of these services should be included in the rule. The descriptions for drug counseling and functional evaluation should clearly distinguish them from ordinary evaluation and management services provided in an office visit. Fee levels should be appropriately set to market levels, with input from the medical and payer communities.

We recommend that payers, or their agents, that organize "Preferred Provider" networks in Tennessee be allowed to negotiate payments for doctors in underserved geographic areas, specialties where willing providers are in critical need for treating injured workers, or out-of-state providers not willing to accept the Tennessee fee

[62] The existing rule, Tenn. Rule 0800-02-18, is well thought out and is supported by competent Division staff; this is a significant asset to build upon for further refinements.
[63] Note that this is one of several possible indices that states now use to annually adjust their fee schedules.
[64] By way of background, between 2008 and 2012 the MEI has averaged annual increases of around 1% per year.

schedule. In addition, negotiated global fees for services should be permitted.[65] Such permission to negotiating fees would involve amending Tenn. Rule 0800-2-17-01.

One purpose of this recommendation is to allow payers to assemble panels of specialists who might not treat injured workers at fee schedule maximums. It is also intended to allow for combined panels of treating physicians, under Tenn. Code 50-6-204. Such panels should only be offered if the physicians who are listed have consented to treat injured workers. Higher fees than the maximum allowable amounts on the fee schedule may be necessary as the price for quality care.

We recommend that Tenn. Rule 0800-2-17-25 be modified to add certified impairment raters to the registry to confirm that MMI has been reached and render an impairment rating. Such certified raters are described in another section of this report. As a concession to the difficulty of learning the AMA system and providing accurate and consistent ratings, the reimbursement rate should be generous enough to incent the needed number of physicians to be on the expanded registry, but not overcompensate beyond what is needed to call out an adequate supply of qualified physicians. The appropriate scale of compensation is presumably less than the $1000 now paid for an evaluation of disputed ratings (now paid to doctors on the Registry). To make impairment ratings as efficient as possible, the current impairment rating form should be reviewed by the Division to determine if the form can be simplified in light of the higher degree of expertise expected from certified, experienced raters.

Outpatient and ASC

At present, Tennessee ASC reimbursement levels are linked to hospital outpatient rates, rather than Medicare ASC schedule. We recommend a switch to the Medicare payment schedule.

Hospital in-patient

We recommend that the hospital in-patient fee schedule more closely align with Medicare reimbursement. The current in-patient schedule, for the most part, is not based on Medicare methods, but reimburses hospitals on a “per diem” basis, with adjustments for outlier cases. Per Diem compensation is not wrong per se, but aligning payment to the Medicare DRG system would be a more standard method of compensation. Moreover, setting and maintaining the per diem rates is inherently difficult across different hospitals and over time. This difficulty in setting effective in-patient payment in the Tennessee system is demonstrated by the 2010 evaluation of fee

[65] Global fees, or payment bundling, is a reimbursement tool that focuses on an episode of care to a provider or clinic. The global fee covers a predefined group of services for the specific patient and injury.

schedule savings by NCCI. It showed almost no savings from the Tennessee hospital fee schedule.

We recommend alignment on the Medicare DRG model for in-patient and outpatient reimbursement. The following overall principle should be followed:

> The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the *Federal Register.*[66]

This model is well understood, allows for outlier cases, and has been shown to be accepted by hospitals in other jurisdictions.[67] Before adopting its Medicare in-patient fee rule in 2008, the Texas Workers' Compensation Commission engaged in exhaustive study of hospital reimbursement systems for HMOs, PPOs, and managed care network. They received input from actuaries, insurers, and hospitals. They determined in rule making that 143% of the total Medicare facility specific reimbursement amount and any applicable outlier payment was reasonable and adequate for in-patient reimbursement, with exceptions for cases with implantable devices that are billed separately. Similarly, they determined that for hospital outpatient cases, 200% of the total Medicare facility specific reimbursement amount and any applicable outlier payment would be adequate. Again there was a separate multiplier for the hospital if a facility or surgical implant provider requested separate reimbursement. Based on the considerable evidence and careful reasoning of the Texas rule, we recommend a similar reimbursement rule for Tennessee. An exception should be made for trauma centers; they should be required to justify a premium over Medicare that is reasonably greater than hospital inpatient reimbursement.

Other issues

Rulemaking to modify the fee schedule will be a complex task that needs to be done carefully and with much interaction with stakeholders. It is suggested that there be at least a two year delay from legislative passage to final rules on the implementation of professional fee changes and a three year delay in institutional schedule changes.

Adopting the Medicare system to workers' compensation requires additions and adjustments to the Medicare rules. The coding and payment levels for services not

[66] Quoted from Texas administrative rule 34.404(f).

[67] Medicare based in-patient fee schedules are used in California, North Dakota, Ohio, Texas, and South Carolina. According to analysis of the Texas Insurance Commission, the inpatient allowable for these states ranges from 115 percent to 140 percent of Medicare reimbursement (found in rule justification for Health Facility Fees 28 TAC §§ 134.403 and 134.404 (2008)).

covered by Medicare, but used in workers' compensation, would need to be carefully studied. Alternative payment rules would have to be put into Tennessee law. We recommend that in the course of updating the fee schedule, ICD-10 coding be recognized for bills after the implementation date for this new coding system.

The above fee schedule disciplines should be considered as a package with other reforms that reduce the "hassle factor" of treating workers' compensation patients. Under the overall reform package, doctors should see a reduction or mitigation in the following problems:

- Having to do impairment ratings, unless they voluntarily choose to specialize in such ratings.
- Fewer encounters with formal utilization review inquiries, and need for medical record transfers.
- Slightly better compensation for office visits.
- A new voluntary option for capturing cost savings from electronic billing.
- Prompt payment of clean bills for services.
- Much less chance of being drawn into litigation.

Expected Outcomes

The impact of these changes will be mixed for non-institutional providers, some finding the changes to be a welcome increase in practice income. ASC and hospital providers will balk at aligning more closely with Medicare and may suffer revenue losses.

- Small net reductions in non-institutional provider fees (with some providers actually receiving higher payments).
- Substantial reductions in ASC and Hospital payments per encounter.
- An overall improvement in the willingness of primary care providers and specialists to treat injured workers.

Report on Advantages of Adoption of Treatment Guidelines

Issue

The quality and cost of medical care rendered to injured workers appears to be a problem throughout the country. The per-claim cost of care has unmistakably risen in most states. High cost is not associated with better quality of care. Rather, dubious surgeries, excessive periods of physical medicine, and overuse of opioids are serious

concerns to many workers' compensation experts. NCCI and WCRI have identified overutilization of medical treatments as a cost driver in some states.[68] Other studies show a wide pattern of treatment practices for similar injuries, which often amounts to under treatment of some injuries.

Tennessee is no exception to this national pattern of medical cost increase. Those responsible for adjudicating medical bills complain of unusual and unnecessary treatments. Combating unnecessary, odd or inexplicable treatment deviations is a source of friction and litigation. Not so visible are the cases where workers are not given the proper treatment to maximize and speed recovery from injury or disease. Even a small number of negligently treated injuries that extend disability or cause suffering to the patient should be unacceptable. The problem seems to be confined to a small number of unorthodox practitioners.

The institution of treatment guidelines appears to have had a useful effect on utilization of services in states where such guidelines have become an official standard. When properly used by claims handlers, treatment guidelines can avert risky and invasive treatments, undertaken without the support of good medical evidence. The key to successful use of an official treatment guide is making it the starting point for a professional discussion with treating physicians about what appear to be unusual treatment plans.

Background

Twenty-four states have adopted treatment guidelines,[69] and there seems to be growing interest by more states in using them. Recent interest in guidelines is shown by adoption in: Delaware (2008), New York (2010), Montana (2011), and Louisiana (2011). Furthermore, strong interest in using guidelines has been expressed by Arizona and Nebraska.

Why this interest? Simply stated, treatment guidelines seem to work. They provide a basis for standardizing treatment of difficult and costly injuries. If applied correctly, they provide a basis for dialogue between medical providers, utilization review experts, and payers.

Treatment guidelines are developed to serve many different purposes. The authorizing legislation for workers' compensation guidelines has a fairly common set of purposes with a similar order of priority. Following is a listing of purposes given for the enactment

[68] The NCCI Report on the 2004 reforms in Tennessee showed evidence of utilization increase and a change in the mix of medical services as a result of the new physician fee schedule. See NCCI, Post-Reform Study of the Medical Fee Schedule Implementation: Effective July 1, 2005, 2010 Edition.

[69] G. Krohm, and J. Wolf Horejsh, *Treatment Guidelines in Workers' Compensation, 2012*, IAIABC, Madison, WI.

of guidelines in the approximate order of frequency in which they are cited by respondents in a WCRI survey[70]:

- Restrict the provision of unnecessary or excessive medical care.
- Encourage quality medical care.
- Improve the consistency of care.
- Assist in clinical decision making.
- Limit cost.

This shows that containing cost is not the primary legislative intent for enacting official guidelines. Additionally, the authors of guidelines generally state in their introductory material that quality of care and the reduction of needlessly risky or ineffective treatment is their primary goal. In their statements of purpose, occupational medicine guidelines also place special emphasis on restoration of function and return to work.

There are a number of different approaches to adopting workers' compensation treatment guidelines:

- Adopting one of the two national, proprietary guides, ODG or ACOEM.
- Developing an in-house state-specific set of guidelines.
- Taking a hybrid approach, using parts of other state or proprietary guides with state specific customization.

Based on the experience of the authors, there are several factors that most contribute to the successful implementation of treatment guidelines:

- They should be credible among users. Credibility stems from the medical authority cited and the expertise and reputation of the authors. Credibility is also enhanced by duration and popularity of use.
- They should be comprehensible. Medical providers must be able to quickly understand the scope of the standard and how to apply it in real clinical practice.
- They should be operational. This is closely related to the above, and refers to the ability of both clinician and utilization review expert to detect whether a standard is being followed or not.
- They should be comprehensive. Treatment guidelines should directly cover the most common of the difficult treatment scenarios likely to be encountered. They need not cover straightforward medical treatment, such as suturing a cut or removing debris from an eye. They should address the most common conditions likely to be encountered in formal utilization review.

[70] Taken from Table 18 in WCRI, "Workers' Compensation Medical Cost Containment: A National Inventory 2011," April 2011, WC-11-35, WCRI, Cambridge, Mass.

Finally, two of the best examples of the need for guidelines are the growing use of back fusions and prolonged treatment of back pain with opioids. There is strong evidence that both are being overused by some doctors (probably represent a small fraction of providers). Moreover, the evidence seems to indicate that injured workers would have better health and job outcomes if these procedures were substantially reduced to more clearly indicated cases. The problem has obviously come to the attention of Tennessee lawmakers who have instituted new controls on pain management practices. (Tenn. Public Chapter 1100).

Recommendations

We recommend that the Workers' Compensation Division be mandated to develop a rule adopting a treatment guideline by a fixed date, ideally within two years. Without a time constraint, experience shows that committees will drag out the decision process. In formulating such a rule, the Division should rely heavily on a medical advisory group composed of medical practitioners most commonly treating workers' compensation injury or disease.[71] It is important that the leadership of this advisory body have quality of care and not cost cutting as the guiding principle. To this end, the Department of Health might well play a lead role in the development of guidelines.

In selecting the guidelines, the Division, and its advisory body, should consider the following criteria and design principles:

- Medical guidelines shall be organized in an interdisciplinary manner by particular regions of the body and organ system.
- Guidelines should be comprehensive enough to cover common treatment problem areas, and in particular they should cover the types of treatments that are most often challenged by UR and appealed to the Medical Director.
- Guidelines should make conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.
- Guidelines should integrate clinical expertise with the best available external clinical evidence from systematic research.
- The presentation of the guidelines should be easily accessible and usable by clinicians.

We further recommend that the adopted guidelines be described as "advisory" for treating physicians. Even so, in the course of its educational programs for medical providers, the Division should promote familiarity with the guidelines.

[71] The Tennessee Medical Association should also be consulted. Some members of the current Medical Cost Containment Committee might be appropriate as well.

Finally, we recommend that the adopted guidelines be used as the exclusive standard for judging the appropriateness of a treatment plan by a UR provider. In issuing an opinion on the necessity of treatment, the UR agent should be required to cite the specific language in the guide that governs the treatment at issue, and how the plan of treatment violates this standard. In turn, if a UR decision denying treatment is appealed, the adopted guideline is the standard by which the appeal should be adjudicated by the Medical Director.

Expected Outcomes

- Adherence to the official standard should help prevent unwarranted UR, which would make occupational medicine more attractive.
- Treating physicians would better understand specifically why their treatment plans were being challenged within the official standard.
- The Medical Director would have a more objective standard for deciding on the merits of a UR appeal.
- To the extent that unjustifiably abnormal treatments were successfully challenged against the adopted guidelines, provider behavior likely would change to avoid such practices.

In measuring the success of this program, the Division should track the issues in dispute during the UR process, and define a standardized reporting practice from UR providers, with respect to denials. In this way, the impact on UR from the adoption of the guidelines can be measured. Moreover, data from NCCI and others on incidence of certain medical procedures and treatments can be tracked to measure impact on incidence from treatment guideline adoption.

Report on Adjustments to the Panel Selection Process

Issue

The process of directing employees to the statutorily required panel of options for treating physicians is not working smoothly. The most common complaint is that employers too often are being required to offer “replacement panels” for both treating physicians and specialists. Also, employees are inappropriately accessing their own doctors for care. In some cases the employee may be misguided by the failure of the employer to provide a proper panel notice when treatment is needed. In other cases, employees may be “doctor shopping” to get a more favorable decision on causation, return to work fitness, MMI or impairment.

Very often, panels are not well formed, and include physicians that, for example, no longer practice, don't provide the care needed, or are not accepting patients, specifically workers' compensation patients.

Additionally, stakeholders report that approved treating physicians sometimes release injured workers from care without offering an opinion as to MMI or impairment rating. It is particularly troublesome when the treating physician releases the patient from his or her care with vague instructions about seeing another doctor. This results in the need for additional panels. These issues are occurring with enough frequency that there is a concern that the panel process is in need of some tightening.

Background

In workers' compensation, choice of treating physician is governed by a wide range of heterogeneous state laws. In fact, there are few major areas of workers' compensation that have such a range of difference among the states. At least two-thirds of states place some material restriction on the choice of medical provider for non-emergency medical care, often known as "employer choice" states. We will confine our attention here to those states.

There are three parts to employer choice: 1) which party chooses the first treating physician; 2) what restrictions are placed on switching doctors for primary care; and 3) what restrictions are placed on referrals to specialists.

Tennessee employer choice has features common among two of its regional neighbors, Alabama and Virginia. These commonalities are: 1) employer (or agent) responsibility to furnish the names of 3-4 physicians not in the same practice group; 2) control on switching primary care doctor vested with employer; and 3) appeal to WC agency for right to switch for cause. Other states in the region provide for managed care organizations and a different choice mechanism within that organization.

Current Tennessee law requires that a C-42 form be completed by an injured worker seeking medical care. A declaration at the top of this form states:

> In compliance with The Tennessee Workers' Compensation Law, T.C.A. Section 50-6-204
>
> The injured employee shall accept the medical benefits afforded hereunder; provided, the employer shall designate a group of three (3) or more reputable physicians or surgeons not associated together in practice, if available in that community, from which the injured employee shall have the privilege of selecting the operating surgeon and the attending physician. If the injury is a

back injury, the statutory panel must be expanded to 4, one of whom must be a chiropractor with treatment limited to 12 chiropractic visits. Further, if the injury or illness requires the treatment of a physician or surgeon who practices orthopedic or neuroscience medicine, the employer **may** appoint a panel practicing orthopedic or neuroscience medicine consisting of 5 physicians, with no more than 4 physicians affiliated in practice. If the employer provides this panel, the injured employee shall be entitled to have a second opinion on the issue of surgery, impairment, and a diagnosis from that same panel.

Discussed below are some of the difficulties in presenting panels that conform to Tennessee law, and, more importantly, provide the employee with good choices of medical practitioners.

Tennessee is following national trends in the way medical practices are organized. A larger share of doctors are treating in large multispecialty practice groups. Fewer doctors practice in solo clinics. In addition, there are many underserved areas.[72] Rural areas may often be served by clinics with only one physician and/or physician assistants and nurse specialists. These rural clinics are often affiliated with a larger hospital based network operating throughout a sub-region of the state. Thus, assembling a panel of three unaffiliated providers presents a problem in rural areas, particularly those designated as underserved counties.

Employers have ample incentive to carefully select doctors for this initial choice by their employee. The treatment given and management of the disability will greatly influence the cost and duration of the injury claim. In addition, the judgment of the treating physician will control key issues in the claim process, not the least of which is causation. In 2011, Tenn. Stat. 50-6-102(12)(A)(ii) was added to address the issue of "doctor shopping" with respect to causation opinions. This change created a presumption that the selected treating physician's opinion as to causation of the injury was correct.

Two big sources of problems with panel selection stem from the circumstances largely beyond the control of the carrier/employer in selecting a valid panel. The first problem is that the employee's choice of doctor may refuse to treat the case. This sometimes happens, when after review of medical records, the doctor elects to not treat that particular injury or patient. The second, after one or more encounters, the provider may end treatment due to incompatibility with the patient. This incompatibility is often mutually felt between the patient and treating doctor.

[72] In 2004, at least 30 Tennessee counties were designated as "health resource shortage areas for primary care." These shortages are mainly in rural areas. Naturally, specialty care is more difficult in rural areas compared to urban areas. For more information see: Tennessee Dept. of Health at: http://health.state.tn.us/rural/haip.html#Shortage

An early relationship with a good treating physician is of the utmost importance to the long-term outcomes of an injury. Additionally, coordination and integration among care providers is essential to better outcomes, including quality of care and lower overall costs.[73] Ideally, the treating physician is not just a link in a chain of successive doctors, but a coordinator of care with a concern for the ultimate outcome of the entire treatment plan. Selecting a good treating physician and maintaining treatment with that clinician is a critical step in this process.

Recommendations

We recommend several measures to strengthen the quality and reliability of panels and maintain their use by injured workers. Employees should be held to their selection of treating physician unless they obtain the voluntary assent of their claims adjuster for a switch to another provider on the original panel. Injured workers should continue to have the right to a second opinion, on matters of surgery, from another physician selected from the originally offered panel. Any other changes, or appeals of the adjuster decision, must be reviewed by the WC Division.

With respect to referral to specialists, however, the law should be modified to require:

1. The treating physician must make the referral and notification sent to employer; and
2. If the treating physician recommends referral to a particular specialist, it is deemed accepted if no action is taken in 3 business days. After notice of referral, the employer may elect to either honor such direct referral without objection, or provide a panel of three relevant specialists, any one of which may be a suitable practice group.

Beyond this, the employer should not be required to provide additional panels at the employee's request. It is recommended that the "larger" panel requirements for orthopedic and neurologic specialists be eliminated.

Additionally, we recommend that the Division be authorized to adopt additional regulations to correct and clarify the panel process. Through regulations some of the current friction points can be clarified and corrected. These clarifications and corrections would include:

[73] In a 2001 study on the causes of poor quality in treatment and excessive disability among injured workers, the authors summarized as follows: "Our investigations have consistently pointed to the lack of coordination and integration of occupational health services as having major adverse effects on quality and health outcomes for workers' compensation." Wickizer, et al., "Improving the Quality of Workers' Compensation Health Care Delivery: the Washington State Occupational Health Services Project," Milbank Quarterly, Vol. 79: 5-33 (Mar. 2001).

- When providing either a treating physician panel or a specialist panel, it is recommended that a referral to a practice group satisfy the requirement for a "reputable physician or surgeon." Any provider or group included on a panel must have been qualified by the adjuster, acting on behalf of the employer, as being willing to treat workers' compensation claimants on a timely basis. The employer should certify in providing the panel to the injured worker that the physicians on the panel have consented to being included on the panel and are willing to treat employees of that company. Consent includes consent to payment terms.
- Providing guidance on the "community" within which panel physicians must be located. For example, if 3 qualified physicians are not located within a reasonable geographic boundary where an injured worker resides, or there is only one practice located there, the boundaries should be expanded, such as to expand to a 100-mile radius.[74] However, there should be circumstances where 3 physicians in one practice group satisfy the panel requirements, such as when the only local physicians are in an affiliated practice group.
- When an injured worker relocates his or her residence, a panel of physicians in the new community must be offered.
- When a physician on the panel refuses to treat an injured worker, and the panel is thereby reduced to a selection from among fewer than three physicians, the worker can either select from the remaining physicians, or request the employer to offer additional physicians, such that the choice is from the required number of physicians. The additional panelists must be promptly provided.
- Upon release of care, physicians should be required, as a condition of payment, to either: (a) place the injured worker at MMI; or (b) make a specific referral for required treatment.
- The C-42 form should be modified to make the both the employee's and employer' rights and responsibilities clear.

It would appear that a part of the friction over doctor panels comes from poor communication between the carrier and employer over the employers' right of selection, and assistance in designating a qualified panel. Employers and out of state adjusters need to be made aware of Tennessee rules on issuing proper panels. They also need to be aware that the panels will need to be updated from time to time to avoid the issue of keeping doctors on the panel that have changed locations or stopped accepting workers compensation patients.

Likewise, there seems to be poor communication between the employer and injured worker regarding the law and each party's duties and rights. Some employers, apparently not aware of the panel selected by their carrier, direct care to non-panel providers, which often necessitates a switch to the insurer's panel. If a valid panel was

[74] Reimbursement for mileage expenses, currently provided by Tenn. Code 50-6-204(a)(6)(A), should continue.

offered at the time a claim was reported, it would greatly curtail the possibility of "doctor shopping."

To reduce multiple panels and “doctor shopping,” it is recommended that the employee should be informed that as a condition of receiving the medical benefits afforded under workers compensation law, the injured worker must follow the procedure provided under the workers’ compensation act. It is important for that the employee sign the C-42 form to acknowledge receipt of this information. In addition, the employer should be obliged to present a form C-42, with the complete information on treating physicians, to any employee that reports an incident that may result in a workers’ compensation claim, regardless of the severity of the injury or medical condition. The employee should be advised that seeking treatment for any condition that is ultimately found to be non-work related will subject that employee to possible payment of bills for medical services. This selection process is not applicable to first aid rendered at the workplace, or for emergency care rendered off site. In such cases the employer has discretion of choice of provider.

Moreover, training of workers’ compensation adjusters who practice in Tennessee should continue to be offered by the Division. This program has been very successful and should be expanded to improve the efficiency of these processes. Notwithstanding Division efforts at education, there still seems to be a number of carriers and third party administrators that do not understand the Tennessee panel system. Apart from the law, some carriers and insured employers do not seem to exploit advantages of carefully screening physicians for the panels.

Finally, a related reform provides for the Division to offer a process whereby a registry of qualified physicians is used for impairment ratings, in place of being provided by a panel physician. It is expected that this will remove some of the friction from physicians declining to treat injured workers because of the requirement to provide ratings.

Expected Outcomes

These recommendations accomplish the following:

- Curtails “doctor shopping” for the sake of gaming the system for treatment the patient desires rather than best medical advice, yet allows switching if a reasonable basis can be offered by the injured worker.
- Eliminates the unjustified special treatment for “orthopedic and neurologic” specialties, which discounts equally valid role of other medical specialties.
- Liberalizes the panel to include a practice group as a single provider, and addresses the growing importance of major networks of providers, which can have a major impact in a small community.

- Clarifies the referral process to specialists, maintains employer role in care, and allows for worker choice, and the right of a second opinion.
- Modifies the C-42 form to make rights and responsibilities clear.
- Authorizes the Division to adopt regulations to better govern the panel process.

To record and monitor the results of these changes would require new data capture systems. Given other demands on the Division, this may be better assessed by a special study within a reasonable time after the initial reform package is implemented.

Report on Improving the Impairment Rating Process

Issue

Impairment ratings are an extremely important part of the workers' compensation system. They are the basis of determining fair and equitable indemnity compensation for injury. Permanent disability is a major share of benefits total workers' compensation benefit payments. However, physicians generally dislike making impairment ratings because they are outside their medical training and tend to be very time consuming. Finally, impairment rating is currently a major source of friction and dispute resolution cost by the state and parties to Tennessee workers' compensation claims.

Background

Tennessee uses the *AMA Guides For Impairment Rating, 6th Edition* as the official standard for how impairment rating should be done and the expected outputs. The WC Division has a specific form (LB-0931A (REV 10/10)) for recording the steps and components of a rating. This form is 18 pages long and requires entry of patient history, treatment record and many factual findings relevant to the rating. Both the *AMA Guides* and the Division procedures are complex and require instruction to perform each step correctly.

One complaint about the current system is that many physicians are unfamiliar with the *AMA Guides*. Despite the fact that they must certify that they knew and followed the AMA 6th Edition, there is evidence that some ratings are uninformed by the *AMA Guides*, or are done in a fairly cursory way.

Even with good familiarity with the *AMA Guides*, there is an inherent difficulty in making impairment ratings that leads to variability and inconsistency in ratings from doctor to

doctor. Thus, one must accept a certain degree of subjective judgment in a rating number.

However, small disputes over amounts or differences of opinion over the application of the *AMA Guides* should not generate formal disputes that draw in extra medical and legal costs in reaching final determination of benefits. This is especially the case if the doctor giving the opinion is qualified to give an accurate opinion, such as on a "registry" of doctors with certain training on ratings. Moreover, efficiency dictates that the rating opinions of doctors on such a "registry" be given a strong presumption of correctness.

Recommendations

It is recommended that all impairment ratings be done by a physician on the list of Medical Impairment Registry maintained by the WC Division. This list already contains more than 140 physicians that have met rigorous standards of training and professional credentials.[75]

Once a treating physician has determined that the patient has reached MMI, he or she must refer the patient to any doctor on the certified list whose office is within 100 miles of the home of the patient. Physicians shall not refer patients to other doctors with whom they share a practice or have any financial or business interest. A treating physician who also happens to be on the certified list may, with the written consent of the patient, be allowed to submit the rating.

The rating by the Certified Rater, properly done on the correct form, shall be presumed correct, absent clear and convincing evidence of error.

Either the injured worker or the employer may request a review of the rating by the WC Division. The specific basis for the appeal of the rating must be shown. A filing fee should be paid with the petition for review to avoid frivolous attempts to overcome the presumption of correctness.

Expected Outcomes

Implementing these recommendations would ease the burden on treating physicians caused by performing impairment ratings. Some physicians are not current on AMA practices and avoid occupational medicine for this reason. These recommendations would lead to improved quality of impairment ratings. These outcomes can be measured by tracking disputes over impairment issues, based on ratings that are not

[75] This list is currently maintained as part of the Division's Medical Impairment Rating process. See Tenn. Code 204(d)(5) & (6), and Tenn. Rule 0800-02-20. This process is used when disputes arise over impairment ratings.

sound. Feedback reports from providers can also measure the need for continual improvement in this area.

Report on Utilization Review

Issue

The utilization review (UR) process is a standard and appropriate part of any workers' compensation system. The UR mechanism should be used to investigate and correct treatment plans that appear to be ill advised or lack clear medical justification. However, the use of outsourced, formal UR in Tennessee seems to be over used and applied to treatment plans that seem reasonably correct in the face of the medical evidence. The frequency of UR challenges is all the more disturbing given the fact that the employers chosen the doctor treating their employees and that the law gives a presumption of correctness of the treating physician's recommendations.

While treatment review can involve a constructive second opinion by a knowledgeable peer, a small fraction of UR agents appear to be rendering sloppy and incomplete reports and "unconscionably" disregarding the medical records. When the UR process delays treatment, especially when exacerbated by a protracted appeal, the injured worker is held in a state of uncertainty and possibly medical risk. UR should be primarily motivated by "the quality and appropriateness of health care," (Tenn. Rule 0800-02-06-.01(23)), not cost avoidance.

Other issues raised by medical providers include the chilling affect that unnecessary or offensive reviews place on the willingness of providers to treat injured workers. Finally, providers resent the fact that some reviews cite unspecified or undocumented guidelines in negating their treatment plans.

Background

UR involves evaluating the quality and appropriateness of medical care in workers' compensation cases in accordance with the timeframes and procedures set out in Tenn. Rule 0800-02-06. In Tennessee workers' compensation cases, UR is required in some instances, e.g. hospital admissions, physical or occupational therapy, chiropractic care, and clinical psychological treatment. Other than these circumstances, UR is up to the discretion of the adjuster.

UR is provided by an individual or entity certified to the Commissioner of Commerce and Insurance pursuant to the state's Health Care Service Utilization Review Act (Tenn. Code

56-6-701 et seq.). The Act, implemented by the Tennessee Department of Commerce and Insurance, requires UR agents to meet the minimum standards set forth in §56-6-705. The Commissioner exempts from these minimum standards any UR agents that are URAC accredited.

The UR agent conducting the review services must be registered with the Division of Workers' Compensation; providers of UR services must be qualified medical practitioners. By rule the Division must review appeals to UR decisions denying treatment.

Insurance carriers and Third Party Administrators have a wide range of approaches to medical review of treatment plans. Many have in-house medical resources to advise adjusters and to single out particularly worrisome treatment plans. Some organizations contract with outside UR firms for routine surveillance of medical bills and treatments. Finally, adjusters often simply have this responsibility as part of their standard role. There is a wide variety of how, when, and why this step is taken, depending on the particular carrier or TPA business model. A payer requesting a UR review bears the cost of the review.

The UR determination must be made in a report conforming to specific rules. A decision to affirm the treatment plan may be made by a licensed nurse; decisions to deny a treatment must be made by a peer medical provider. If the treatment is approved, then the decision is final. If the treatment is denied, then the party seeking approval of the treatment (the injured worker or his or her treating physician) can appeal the decision to the Division. The Medical Director reviews the record, and issues a decision either upholding or reversing the denial of the treatment. If the denial is upheld, then the parties can request a waiver of the BRC process, after which further review is allowed to circuit court.

There are numerous time requirements involved in this process, including conditions on when deadlines may be extended. There are also numerous provisions about the exchange of medical records between the physician, the adjuster, and the UR provider, some of which are designed to work around privacy constraints. The timely exchange of medical records seems to be causing long lag times in the appeal process. All of these delays result in delays in treatment, which further result in poor outcomes.

Division statistics indicate that during the fiscal year just ended June 30, 2012, there were 18,566 notifications of UR received by the Division, and 1,188 new appeals of denials to the Division. There were 159 appeals pending when the year began. Of these appeals, 521 of the denials were affirmed, 309 were overturned and treatment approved, and 381 were administratively closed, either because the denial was overturned by the adjuster or the treatment was no longer needed or requested.

Recommendations

In general, Tenn. Rule 0800-02-06 provides a clear and orderly process for utilization review. We recommend the following incremental changes that could have a powerful effect in reducing unnecessary frustration and cost to injured workers, treating physicians, and the Division staff:

- Create a presumption that treatment is reasonable and necessary if recommended by the panel physician. Such a presumption would be similar to that currently in place for issues of causation. Tenn. Code 50-6-102(12)(A)(ii). This presumption would be even more formidable if treatment conformed to state adopted guidelines.
- If the adjuster conducts UR, and the UR report shows that the treatment is within guidelines[76], then the treatment is approved and the approval decision is final and binding on the parties, as set forth in Tenn. Rule 0800-02-06-.06(4), and the adjuster should promptly confirm agreement on the treatment plan; If the UR report shows that the treatment is not within guidelines, then the report must identify what specifically is objected to in the treatment plan. On the basis of this UR objection, the claims handler may deny the treatment plan either in whole or in part, and discuss alternatives to expedite care for the injured worker.
- A denial of treatment may be appealed to the Division. The Division should be authorized to adopt rules that create a penalty and fee-shifting program where appropriate, to both discourage unwarranted appeals and unwarranted UR denials. The penalties should be large enough to discourage frivolous requests for appeal but not so large as to impede appeal to obtain what the medical provider believes are substantial and necessary treatments.[77]
- If the denial is confirmed, then an RFA may be filed, and the case mediated or ultimately tried. A Denial that is confirmed by the Medical Director should be presumed to be correct, and only overturned by clear and convincing evidence to the contrary.
- If the denial is reversed, the treatment is considered approved and the decision is final and binding on the parties.

Additionally, penalties already contemplated by Tenn. Rule 0800-02-06-.10 should be enforced by the Division's Medical Director for negligent or non-complying reports by UR agents. Disciplinary actions should follow specific steps of progression:

> *Step 1:* correction letter(s) from the Medical Director noting problems with specific reports, or failure to follow Division rules.

[76] It is assumed that official treatment guidelines will be adopted, as recommended elsewhere in this report. Until such guidelines are in place, the UR agent will continue to use whatever standard of treatment they deem appropriate.

[77] The Division is currently authorized to require fees for appeals, but fees are not being charged.

Step 2: notice of probation shall be sent from the Medical Director to any UR agent that continues patterns of poor performance after correction letters; probation establishes that the agent's work will be closely reviewed for possible suspension of rights.

Step 3: temporary or permanent suspension of the right to perform utilization review services for workers' compensation claims; this must be based on a continued occurrence of violations of Division rules or procedures, beyond those documented in previous steps.

Notices of probation or suspension shall be posted on the Division website along with the annual agent reports currently required by rule.

We are keenly aware of the heavy workloads currently created by UR appeals. Imposing new enforcement requirements on staff would be impractical, unless there was a realistic belief that appeal levels could be brought down or burdens of collecting complete medical records reduced. We believe that reforms recommended here will free up staff for more proactive education of stakeholders and enforcement against chronic violators.

The statute should be amended to authorize the Division to better define obligations on the exchange of medical records:

- It is the sole responsibility of the petitioner to forward the complete medical record to the Division with the application for review.
- If the claimant is represented by counsel, it is the responsibility of counsel to obtain complete medical records along with the application for appeal.
- It is the duty of the UR agent to examine the complete record of all records relevant to the treatment in dispute; records which are missing from those forwarded by the adjuster requesting the services of the UR agent may not be sufficient; the UR agent is responsible for making a review based on the complete, relevant medical record.

A related reform addresses tightening the use of physician panels. We expect that fewer disputes about treatment will arise if a strong presumption of correctness is applied to the judgments of properly selected treating physicians. This presumption will have more merit and enjoy the confidence of all parties to the claim if employers take very seriously the selection of a physician panel.

Expected Outcomes

- The perception of the practice of occupational medicine will be substantially enhanced by curtailing abuses of UR.
- Employers will be able to form, and employees select from, panels from a larger population of doctors willing to treat workers' compensation patients.
- Workloads for the Medical Director and staff will be reduced.

It would be relatively easy to collect metrics on Division staff workloads before and after this reform, including the necessity to handle defective applications and lack of medical records. It will difficult to measure the improvement in the willingness of providers to treat injured workers solely as a result of this reform.

Electronic Billing System for Workers' Compensation

Issue

Electronic billing and payment systems are now standard for health delivery systems outside of workers' compensation. Known as "E-Billing," these methods offer gains to medical providers and payers with relatively little development cost or overhead. Tennessee currently has not formally adopted an E-Billing payment program.

Background

One of the surest ways for improving the efficiency of the provision of medical services is through the streamlining of the "backroom" administrative practices of the system, including billing and payment follow up. The American Medical Association (AMA) has made the streamlining of billing and payment systems a major policy initiative.

The billing problem is greater for workers' compensation than general health insurance. Workers' compensation has greater complexity of paper flows surrounding medical treatments, particularly in the routine requests for complete medical records. Medical providers that treat workers' compensation patients are overwhelmed with the information flows required to practice medicine and get paid. Granted, payers need accurate and timely information to manage claims and manage treatment and cost issues. Technology can assist this process by providing information that payers need and at the same time reducing paperwork and speeding payment.

E-Billing, using national standards and rules, has emerged as one clear answer to the demands of stakeholders. Texas, California, Louisiana, Illinois and Oregon currently have E-Billing mandates for the use of E-Billing. Other states have expressed strong interest.

E-Billing allows providers to submit bills for services and related information electronically and receive information about the payment status of those bills. The system is voluntary for providers, but payers must accept electronic bills and return electronic acknowledgements.

The International Association of Industrial Accident Boards and Commissions (IAIABC) has developed a model law for the implementation of E-Billing. This model has been used in other states and can greatly simplify implementation. In addition, the IAIABC has a "companion guide" that states can use to assist medical providers in explaining the E-Billing system.

Recommendations

We recommend that Tenn. Rule 0800-02-17-.10(7) be replaced with the IAIABC model rule on E-Billing. The state would establish the E-billing standard and direct that all workers' compensation payers accept electronic bills and process acknowledgements according to the standard. Before implementing such a standard, an education and outreach program will be useful.

Expected Outcomes

- A gradual increase in the number of medical providers that submit their bills electronically.
- Few carrier compliance problems.
- A substantial acceleration in the average time of payment for medical bills submitted electronically versus in paper form.

Report on the Unresolved Issues of An Option for Employers to "Opt-Out" of Workers' Compensation

Issue

Reports from the WC Division on stakeholder listening sessions indicate that a small group of employers have a keen interest in a system allowing them, under certain circumstances, to "un-subscribe" to the WC system. We have no way to quantifying the number of such employers, their size, or their actual will to "opt-out" under various regulatory restrictions.

There are manifold reasons for this motivation to leave the workers' compensation system. Employers with operations in Tennessee and Texas can cite lower employee benefit costs for their operations in Texas where they have elected to opt-out of workers' compensation. They certainly have far more administrative discretion in how and when to provide benefits. Possibly, the advocates feel they will rarely be sued successfully, and that their legal liability and defense costs under tort will be less than their workers' compensation costs.

Another likely motivation for opting out is the litigation costs and administrative overhead of the WC system. The procedures to protect the claiming rights of injured workers, both in Tennessee and as well as across the country, are often seen as inefficient, arbitrary or onerous by some employers. As discussed below under ERISA, we might presume that the employers could exercise far more control on a short-term disability insurance plan than on a workers' compensation indemnity claim.

Thus, opt-out confers many possible advantages on the firms electing to leave the workers' compensation system. Conversely, it creates financial risks and likely costs to their workers. As discussed below, it also creates adverse consequences to other employers in Tennessee and the State itself.

Background

Texas is the only working model for allowing private employers (otherwise covered by the workers' compensation act) to opt out of the system.[78] However, other models have been proposed. This section discusses some of the major strengths and weaknesses of these models.

Various regulatory conditions can be imposed on firms wishing to opt-out, e.g., financial strength, non-workers' compensation benefit plans, and loss of legal defenses in tort. Policy makers need to understand the "strings" that proponents are willing to accept as the condition for opting out, and balance regulatory protections against other stakeholder needs.

Some employers point to the Texas opt-out, or non-subscription system, as a model. There are many devotees in Texas, who have formed the Texas Association of Responsible Nonsubscribers.

[78] It is important to note that small employers in Tennessee, and most other states, are essentially allowed to "opt out" by keeping employment rolls below the 5 employee statutory coverage trigger. Exemptions are often applied to certain employments as well, such as domestic service and farming. Such scenarios, because of their size, do not represent valid points of comparison for larger employers exiting the system.

As practiced in Texas, the opt out program—generally but not always—turns workers' into an employee benefit program like health insurance and short term disability. Opt-out firms are called "non subscribers." Benefit levels are discretionary for the employer and the rules for accessing the benefits are up to the employer within the requirements of ERISA (for nongovernmental entities). No level of medical or disability benefits is required by statute.

About one third of employers in Texas have opted out, covering about 25% of workforce. Of those employers who opted out, half offer no benefits to injured workers. In essence, these employers have chosen to return to the pre-workers' compensation legal environment, where the only recovery of damages not voluntarily paid by the employer was from a successful lawsuit. However, these companies without benefits employ a small fraction of the workers within opt-out firms. More than not, firms offer financial benefits relating to workplace injuries. As shown in a survey of over 50 Texas non-subscribers, benefits include:

- Paid indemnity from day 1.
- Mandatory arbitration.
- Most stop TTD after 2 years and cap permanent if they provide PPD.
- Some buy AD&D policy for TTD, death and dismemberment.

It should be understood that the above benefit offerings are at the employer's sole discretion.

Tennessee firms who have operations in Texas and have opted out there include: Best Buy, Cracker Barrel, Community Health, Marriott, Jack in the Box, McDonalds, Long John Silver's, Dollar General, Auto Zone, Tractor Supply, Averitt Trucking, Target and Wal-Mart.

Some Tennessee businesses reportedly favor the proposed opt-out system that was narrowly defeated this year in the Oklahoma legislature this year. The proposed Oklahoma system is quite different than the Texas system. The optional plan would have been required to come under ERISA. It would only have been available to employers who had a specified financial strength and loss experience. The proposed plan in Oklahoma requires the employer to provide some level of benefits for sickness, injury or death not due to an occupational injury.

The benefits offered by some opt-out firms in Texas, and in the Oklahoma bill, would fall under the control of the Employee Retirement Income Security Act (ERISA), regulated by the US Department of Labor. Any state is federally pre-empted from any enforcement authority on non-workers' compensation benefit plans. In such cases the state would lose practical enforcement control over benefit amount, eligibility or delivery mechanism. Clearly, they cannot regulate, as they can under workers' compensation,

prompt delivery of promised benefits, resolve disputes over eligibility and compensation, and provide other assistance and relief to injured workers.

Workers' compensation systems in every state take extreme measures to guarantee payment of statutory benefits. Among the steps taken, self-insured employers not only must be sufficiently well financed to pay claims directly, but also are required to post significant financial security as a backstop against insolvency. To further guarantee the obligations of a self-insured, some states also maintain workers' compensation self-insurance guaranty funds, financed by self-insured employers in the state, to pay benefits should a self-insured employer become insolvent. States without guaranty funds make other self-insureds jointly and severally liable for the default of another self-insured. For commercially insured employers, the obligations of insurers to injured workers are protected from the insurer's insolvency through insurance guaranty funds. These funds exist in every state and pay 100% of benefits owed to covered workers.[79] These considerable guaranties vanish when a firm opts-out. The public policy question is then: How will employers opting-out replicate workers' compensation's extremely strong benefit guaranty?

Workers are exposed to new risks and uncertainty if their employer opts out of the system. Assuming that an employer voluntarily elects to supply comprehensive 24 hour coverage for medical and disability problems, how likely is it that a worker will exceed the ERISA plan benefits from a disabling injury that is not the legal responsibility of the employer? There is no comprehensive "score card" to show how many Texas workers obtain fewer benefits under the alternative to workers' compensation. A prima facie case can be made that opt-out is most likely to disadvantage severely injured or killed workers. Even assuming voluntary coverage of short term medical and disability costs, a severely injured worker would suffer lifetime earnings losses and ongoing medical expenses.

Opt-out is viewed negatively by labor advocates because of the lack of procedural controls and employee rights. The opt-out employer has discretion about the level of payment it will make to its workers in case of work-related injury or illness, including wage replacement and the type and extent of medical care. Moreover, the employer has the sole authority to decide who is eligible and which injuries and illnesses are covered under the benefit plan. Disputes about benefits are determined by the employer. As discussed above, benefit payment is not secured nearly as well as under workers' compensation law.

Jason Ohana reports that a substantial share of Texas non-subscribers force their employees to sign waivers of negligence claims against their employer as a condition of receiving benefits. If this is correct, the worker is forced to trade inferior benefits for the

[79] See www.ncigf.org (website for the National Conference of Insurance Guaranty Funds)

right of seeking full damage recovery in court. According to this author, states are pre-empted from barring such waivers.[80]

Finally, workers' compensation insurance companies will view the opt-out option as impacting their ability to effectively and affordably provide coverage to those remaining in the system. The American Insurance Association has pointed to uncertainty in pricing risk on workers' compensation coverage, as well as the inability to accurately balance experience. Additionally, there will be a loss of premium revenue. However, disability income and other liability insurers likely will see an increase in premium revenue. In any case, gains and losses from different insurers should not drive public policy on this issue.

Possible Benefits to Opt-Out Employers

A driving force behind opt-out is lower health and income replacement costs, which result from several factors:

- Better control over medical costs.
- Perceived earlier return to work.
- Permanent Partial Disability benefits not required.
- Employer has control of the plan of benefits; e.g., permanent partial disability benefits are not required.
- More internal control over fraudulent claims.
- Lack of government regulations.
- Predictability; many plans have time limits on benefits, such as 2 years.
- Perceived greater sense of conflict avoidance.
- Some think employers are more safety conscious.
- Perception that workplaces are safer.

Other considerations:

- Tort liability is not perceived to be a problem (in Texas and among Tennessee government units opting-out).
- Opt out is perceived to be a better fit for low risk industries, or those with superior loss control and disability management programs.

Possible Arguments against an Opt Out Option

[80] Ohana, J., "Texas Elective Workers' Compensation: A Model of Innovation?" William & Mary Business Law Review, 2011, Vol. 2, Issue 2, Article 5.

As attractive as opt-out is to some employers, it has some possible disadvantages for workers, other employers, and the state.

First, there would be two categories of workers: those who received the coverage and processes guaranteed by workers' compensation, and those who received discretionary benefits without the same appeal or process rights as in workers' compensation. This distinction will be opposed by labor advocates. The biggest differences in benefits would be for catastrophically injured workers and short term/part-time employees.

Second, to the extent employers with better than average safety and workers' compensation program left the insurance pool,[81] the insurance rates for other employers in their industry likely would go up. This possible effect on the insurance market should not, in principle, block firms from opting out, but it should be considered as a likely consequence.

Third, it is likely that Social Security Disability Insurance costs would increase. Few opt-out employers would provide for total and permanent disability indemnity. Likewise, there may be greater outlays for TennCare for injured employees of companies that opted out and provided no medical benefits. Also, the dependents of long-term disabled workers would likely seek charity care of TennCare for their medical needs.

Fourth, the workers' compensation premium tax revenues collected by the state would be diminished. Moreover, the second injury fund would be adversely impacted.

Recommendations

We recommend against an opt-out option for Tennessee employers, at least until the defects noted below can be remedied, shown to be immaterial.

Even with restrictions on the types of employers than can opt-out and requirements on the type of alternative benefit structures they must offer, giving firms this option would have potentially significant negative consequences on some injured workers, other Tennessee employers, and the state taxpayers generally.

For opt-out to become an acceptable alternative to workers' compensation, the following apparent defects must be remedied:

- Benefits must be sufficiently robust so as to protect injured employees for both medical care and lost wages during disability, particular those with catastrophic injuries. Neither the Texas system nor the failed Oklahoma bill had a defined

[81] One might predict that firms with poor safety records would not want to opt out because of the higher risk of losing tort actions for injury damages.

benefit structure that covers the needs of injured employees with above average injury severity.

- Benefits must be secure against default by insolvency. Employer bankruptcy could curtail some benefits to injured workers. Likewise, a large civil award for a seriously injured worker may trigger bankruptcy for a weakly capitalized and poorly insured firm.
- Employer defenses in civil actions must be limited, especially for fellow employee negligence and assumption of risk.
- Employees must not accept as a condition of employment or benefits the waiver of rights to sue the employer.
- The loss of premium tax revenues should be forecast and budgeted.

Because Texas is the only working model for the opt-out option for large private firms, it is vital to have a better understanding of the consequences of such an option to all the stakeholders in the system. Finally, several reforms to the workers' compensation system are underway, and more are being recommended. These reforms are likely to correct many of the cost and administrative issues raised by employers and that drive them to seek an alternative. Reforms likely will take some time, at least 1-2 years, to begin to realize their intended purpose. Creating an opt-out program on top of such reforms, however, would likely be disruptive and potentially undermine the progress that such reforms are designed to accomplish.

Ombudsman Program

Issue

It is difficult for most workers and employers in general to understand the workers' compensation system. Programs vary widely from state to state, and are governed by specific and detailed processes that are set forth in difficult-to-comprehend laws and procedures. There should be little wonder that misunderstandings over the requirements of the law are all too common. Moreover, the consequences of escalating misunderstandings into formal legal battles are harmful to both workers and employers.

In general, state workers' compensation agencies try to address the needs of parties with difficulties understanding the claims process. Stakeholder feedback indicates that the Tennessee Division of Workers' Compensation seems to be better than most agencies in assisting stakeholders and resolving issues. There is concern that structural changes, however, are needed to provide for greater assistance.

As described in other reports in this study, Tennessee has some unusual procedures for resolving disputes over workers' compensation coverage and benefits. Moreover, the Division is not the "general arbiter" of workers' compensation issues, because of the role of the courts in Tennessee. Undertaking reform in these areas will help alleviate many of the issues faced by unpredictable, inconsistent, and confusing results, and help provide better service to pro-se litigants.

As part of the reforms of the dispute resolution system, however, it is fundamental that an informal, albeit structured and pro-active program be implemented to stem the progression of misunderstandings and mistakes into formal disputes and litigation.

Background

There is good evidence that people with workers' compensation claims behave differently than their co-workers without claims. They are under different stresses, like pain, financial worries, and confusion about what to do. The common experience of people who seek help for the resolution of disputes outside compensation systems is that they seek acknowledgment, apology, comfort and someone to help them get beyond the current situation. Rarely is the primary motivation to obtain some financial gain, even though a desire for punishment for misbehavior may be present.

Good informal dispute resolution systems in compensation systems are designed to fulfill these functions. First, they inform and educate because the root of miscommunication and misunderstanding is often ignorance of the rights and obligations the parties must accept. Second, they facilitate communications, to prevent those disputes that are caused by communication errors. Finally, they bring detached wisdom to the dispute, facilitating an agreement that lets the parties move on before either side "digs in its heels." These functions should be performed by a neutral party that has no impact upon the formal resolution of cases, so that agreement, compromise and apology can occur without legal consequences. These are the proper functions of an ombudsman program, which is the appropriate "first step" in minimizing formal disputes.

Several states have created formal ombudsman programs to accomplish these objectives. For example, in Alabama the workers' compensation statute provides for creation of an "Ombudsman Program to assist injured or disabled employees, persons claiming death benefits, employers, and other persons in protecting their rights and obtaining information available under the Workers' Compensation Law." Ala. Code 25-5-290.[82] States vary in explicitly directing the program by statute either to assist injured

[82] In Arkansas, the pre-hearing program is called a "preliminary conference procedure." Ark. Code 11-9-703. The program is mandatory, depending on the amount in dispute, currently $2,500 or less. Other state statutes direct creating similar programs. *See, e.g.*, Fla. Stat. 440-191 ("Employee Assistance and

workers, or to assist all stakeholders. In Arizona, for example, the workers' compensation statute provides that the state "shall employ an ombudsman to assist recipients of workers' compensation benefits" and that the "ombudsman shall not provide legal advice but may provide information about the workers' compensation system and rules governing commission proceedings and may assist in clarifying the methods used to determine a person's workers' compensation benefits." Ariz. Stat. 23-110.

In Tennessee, at present these functions are assigned to workers' compensation specialists pursuant to Tenn. Code 50-6-236. The Division recently has made changes to its dispute resolution processes that have improved consistency. Unfortunately, there are some structural issues. For example, the venue for their efforts often is a benefit review conference, which occurs after a disagreement on the issues of maximum medical improvement (MMI) or impairment ratings. By this time, any opportunity to avoid disputes before the parties have involved attorneys and "dug in" their positions has been lost. Specialists also perform ad-hoc issue resolution assistance throughout the life of a claim, particularly after the filing of a Request for Assistance, and are able to resolve many problems in this manner. Providing additional structure and credibility would serve to advance and improve upon these efforts.

Recommendations

We recommend that the Division be mandated to establish an Ombudsman program and that appropriate funding be provided. The purpose would be to provide a mechanism for avoidance of disputes that can be resolved by facilitating communications, educating parties as to their rights and obligations and facilitating resolutions outside the legal process. The ombudsmen would also assist with completing forms.

Details

The following details help ensure creation of a robust pre-litigation dispute resolution process that would encourage the parties to resolve issues at the earliest possible stage, and with the lowest possible level of formality and cost. This process would work as follows:

1. Ombudsmen and their Role
    a. The Administrative Director shall employ personnel who are knowledgeable about workers' compensation law and procedures to

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Ombudsman Office"); Ky. Stat. 342.329 ("Division of Ombudsman and Workers' Compensation Specialist Services"); and Okla. Code 85-3.9 ("Workers' Compensation Counselor Program"). Some statutory examples are provided in the Appendix to this report.

assist all parties in informal measures to help avoid potential disputes from requiring additional intervention. These persons shall be known as ombudsmen.

b. An ombudsman shall be a neutral party who is available to potential disputants and service providers in the workers' compensation system for the purpose of:
    i. Providing education concerning the rights and obligations of all parties and service providers under the workers' compensation law, and answering specific questions posed to them to the best of their ability;
    ii. Providing a mechanism for facilitating the communications between the parties, or between a party and a service provider, for the purpose of clarifying positions, discerning and rectifying miscommunication and reducing any anger or frustration experienced by the parties in the process of communications during the claims management process;
    iii. Assisting the parties to come to a voluntary agreement to resolve their issues, and to assist them in documenting that agreement where appropriate; and
    iv. Assisting any potential party to a proceeding before the Division with completing forms and applications required to place their claim into the mediation process.
c. Ombudsmen shall not provide assistance to anyone who employs an attorney for the purpose of representing them on the same matter.
d. Ombudsmen shall clearly inform all parties that they deal with in the course of their official business that they are not attorneys, must strictly avoid giving legal advice as would an attorney, and cannot guarantee that a court will agree with their interpretation of the law, rules or procedures.
e. Ombudsmen shall not investigate alleged wrongdoing disclosed in the course of their services, but may refer suspected wrongdoing for further investigation.
f. No statement, discussion, evidence, allegation or other matter of legal significance, that occurs in a discussion with, or in the presence with an ombudsman shall be admissible as evidence in any other proceeding.
g. Forms, applications and other materials that an ombudsman assists a party in preparing shall be signed by the party. The ombudsman shall not attend any further proceedings on the matter and shall not sign any form, pleading or application on behalf of another. An ombudsman shall not accompany any party to court but may provide general assistance to any party in preparation for further proceedings.
h. Ombudsmen serve at the pleasure of the Division Administrator, and may be terminated for any offense justifying dismissal that is standard for other Division employees, including for lack of necessary neutrality.

i. The Division Administrator shall provide for adequate initial and continuing training for ombudsmen.

2. Sanctions for non-compliance with informal dispute resolution
    a. It shall be the duty of entities covered under the workers' compensation law and their agents to comply with the mandatory provisions of the ombudsman and mediation provisions, and to reasonably cooperate with ombudsmen and mediators.
    b. The Division Administrator may, after notice and an opportunity to be heard, impose sanctions for any violation of the duty to comply and cooperate with the ombudsman and mediation processes demonstrated by clear and convincing evidence. The sanctions available for imposition shall include economic sanctions, and equitable relief reasonably designed to restore the parties to their status prior to the violation of duty and deter future violations. Any economic sanctions shall be paid to a fund used to facilitate public education regarding the workers' compensation laws of Tennessee. The provisions of the UAPA shall not apply. Parties aggrieved by the actions of the Division Administrator pursuant to this paragraph may seek a remedy by way of writ of mandamus or prohibition, pursuant to the applicable rules of appellate procedure.

Expected Outcomes

Developing a corps of well-trained and effective ombudsmen will lead to fewer disputes, better-informed stakeholders, and more efficient operations. Careful metrics should be collected on the program, including stakeholder contacts, issue description, and outcomes. The impact on overall dispute resolution should be measured as well. Stakeholder feedback should be collected and used to shape and improve the program.

Expansion of Drug and Alcohol Presumption

Issue

In Tennessee, a presumption that an injury was caused by the use of illegal drugs or alcohol is available to certain employers as a defense against payment of workers' compensation benefits. This presumption, set forth in Tennessee Code 50-6-110(c), is available to employers that participate in the Tennessee Drug-Free Workplace Program. Participation in the Drug-Free Workforce Program also entitles employers to premium discounts on their workers' compensation insurance policies.

Some stakeholders have expressed interest in expanding this presumption to cover all employment, regardless of participation of the Drug-Free Workforce Program. From a policy perspective, such an expansion would serve to: 1) help promote drug and alcohol-abuse free workplaces that are safer and more productive, see Tenn. Code 50-9-101(a), and 2) provide more employers with the presumption defense in workers' compensation cases.

Background

By way of background, the Drug-Free Workplace Program (DFWP) is voluntary and employers must meet a number of requirements to enroll in the program. Employees working in drug-free workplaces face the risk of unemployment and the forfeiture of workers' compensation benefits if they fail a drug test ordered by their employer, or refuse to be tested. If an injured worker, at the time of the injury, has a positive drug or alcohol test at the levels prescribed in the rule, or refuses to be tested, then it is presumed that the drug or alcohol caused the injury, in violation of Tenn. Code 50-6-110(a)(3), which prohibits compensation for injuries caused by an "employee's intoxication or illegal drug usage." This presumption may be rebutted by "clear and convincing evidence that the drug or alcohol was not the proximate cause of the injury."

The DFWP has a broader scope than workers' compensation presumptions. As mentioned above, participating employers receive premium discounts. Moreover, participating employers must perform certain routine tests at hiring, upon "reasonable suspicion" of violation of the policy, at regular intervals if required by the employer's policy, and in follow up to participation in drug or alcohol rehabilitation programs.

The presumption and disqualification for benefits could be extended in law to all employers regardless of participation in the DFWP. Other states have taken this step. Arkansas, for example, provides for a general presumption that drug or alcohol use caused a workplace accident if there is a "presence of alcohol, illegal drugs or prescription drugs used in contravention of a physician's orders." Ark. Code 11-9-102.

In Virginia, a positive drug or alcohol test at certain levels provides an employer with a presumption that an employee was intoxicated at the time of an injury. This presumption can be rebutted by the employee with "clear and convincing evidence." Thus, "intoxication" is presumed, but not causation; the employer is still required to show that the cause of the workplace injury was the employee's intoxication.[83]

[83] Virginia Code 65.2-306 provides as follows:

> However, if the employer raises as a defense the employee's intoxication or use of a nonprescribed controlled substance identified as such in Chapter 34 of Title 54.1, and there was at the time of the injury an amount of alcohol or nonprescribed controlled substance in the bodily fluids of the employee which (i) is equal to or greater than the standard set forth in § 18.2-266, or (ii) in the case of use of a nonprescribed controlled substance, yields a

This distinction between the Virginia and Arkansas provisions highlights one critical issue that must be part of revising the drug and alcohol presumption in Tennessee, namely, the nature of the expansion. Other issues relevant to such a revision include:

- What notice, if any, should employees have that they might be subject to testing? There does not appear to be a general legal prohibition in Tennessee against employers conducting drug testing.
- What impact, if any, do collective bargaining agreements have on the process? In theory, collective bargaining agreements can cover restrictions on drug and alcohol testing. Without specific language, if the procedures allowed do not conform to the testing procedures for the drug and alcohol presumption, then a positive test under the collective bargaining agreement would not trigger the presumption. By way of reference, the DFWP provisions are subject to applicable collective bargaining agreements, which would indicate that provisions in a collective bargaining agreement would control application of the DFWP presumption. An amendment to the Workers' Compensation Law, however, to expand the drug and alcohol presumption would seemingly apply regardless of a collective bargaining agreement, because the terms of the WC Law cannot be waived by employers and employees. The collective bargaining agreement could very well limit testing, however, which would serve to limit application of such a drug and alcohol presumption.

Recommendations

We recommend that the drug and alcohol presumption be expanded to cover all employments in Tennessee. From an overall policy perspective, this serves to promote drug and alcohol abuse free workplaces, which are inherently safer. From a workers' compensation procedural perspective, however, we would recommend an expansion to presume only "intoxication," as seen in the Virginia approach, as opposed to "causation," as seen in the Arkansas approach. This would be a narrower presumption than that currently available under the DFWP.

We make this recommendation for four reasons. First, it encourages full participation in the DFWP, which is a carefully constructed balancing of interests to promote broad

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positive test result from a Substance Abuse and Mental Health Services Administration (SAMHSA) certified laboratory, there shall be a rebuttable presumption, which presumption shall not be available if the employee dies as a result of his injuries, that the employee was intoxicated due to the consumption of alcohol or using a nonprescribed controlled substance at the time of his injury. The employee may overcome such a presumption by clear and convincing evidence.

policy goals. It accomplishes this by offering not only a presumption of "causation," but also a premium discount.

Second, adding a presumption that is narrower than the DFWP statute means that the DFWP statute does not have to be repealed or revised, which encourages stability in the law and rewards current participants. Rather, there would simply be a new provision, in the available defenses section, that would add the "intoxication" presumption. We suggest mirroring Virginia's provision.

Third, a presumption of "intoxication" is somewhat more rational than a presumption of "causation." Causation in and of itself requires, at times, an inherently complex analysis, and our overall recommendations for reform include an effort to clarify that very standard. Although the DFWP provides for just such a presumption, that statute is part of an overall program of workplace safety, including pre-employment and random testing. Not requiring that additional process and providing for what would be a relatively severe shifting of the burden of proof does not strike the same balance as was set forth in enacting the DFWP.

Fourth, an "intoxication" presumption is an incremental step towards addressing the issues of encouraging workplace safety and alleviating difficulties of proof in the face of evidence of, at a minimum, reckless behavior by drug and alcohol abuse in the workplace. Moreover, from a cost perspective, there is no compelling or even minimal evidence that the likely result of efforts in this area will lead to lower costs.

Given the comprehensive nature of the several recommended reforms, we believe that an incremental extension, to cover a presumption of "intoxication" if test results show a certain level of drugs or alcohol, to be advised at this time.

Expected Outcomes

These recommendations will lead to additional clarity in resolving causation disputes when an injured worker was intoxicated at the time of the injury. There is potential that these recommendations would further the policy goals of the DFWP and reduce the incidence of improper drug and alcohol use in the workplace. The impact of the change can be measured through issue tracking in the dispute resolution processes.

Effective Education and Outreach Programs

Issue

A high-quality, proactive education and outreach program is vital to keeping stakeholders informed about the functions of Tennessee's workers' compensation program. Workers' compensation is a complex and intricate system, and thus developing creative and effective mechanisms, in ways that remain practical and relevant to stakeholders, is a constant challenge. Better-informed stakeholders apply the law more consistently and equitably, reducing unnecessary disputes and delays, improving services, and lowering costs. A benefit to the Division is lower enforcement costs, in the form of penalties or corrective actions. Moreover, Division staff will spend less time working around or repairing mistakes made by non-complying entities.

Background

Like almost any system, accurate, timely, and relevant information help make a workers' compensation system function better. Treatment is more prompt. Workers return to work more quickly. In short, the law is more self-executing and there are fewer disputes and misunderstandings. As described in the WCRI report *Dispute Prevention and Resolution in Workers' Compensation, A National Inventory 1997-1998*, "Dispute prevention and dispute resolution are best thought of as a continuum of actions designed to increase certainty, consistency, and communication."[84] Effective action in this regard serves to "reduce delay and friction costs" in workers' compensation systems.[85]

Evidence shows that effective return-to-work programs lead to better outcomes, not just from an employer and employee perspective, but to the system as a whole, in terms of reduced disputes and overall costs. Effective "disability management" programs have been described as follows:

> Disability management promotes a "win-win" philosophy of gains for both the employer and the employee. The employee gets back to work sooner with less wage loss and a reduced expectation of permanent impairment. The employer gets the employee back at work to minimize interference with production and with reduced costs for workers' compensation and other benefit programs.[86]

Proactive education and information to stakeholders about such programs is the first step to successful implementation.

The Division currently provides written and online information for stakeholders. Answers to frequently asked questions on the Division website provide helpful

[84] Ballantyne, D., WC-98-3, p.7 (WCRI 1998).
[85] *Id.*
[86] Hunt, H.A., *The Evolution of Disability Management in North American Workers' Compensation Programs* (Upjohn Report 2009), available at http://research.upjohn.org/reports/179.

information. A recently launched training curriculum for adjusters has been well received.

Recommendations

The Division should continue with its current outreach efforts and expand to other areas, with the following objectives:

- Workers should understand their rights and the general nature of benefits they are entitled to. They should also be informed as to how the medical delivery process operates, in particular their obligation to choose a treating physician from an employer list.
- Employers, particularly small employers, should be schooled in practical information about the workers' compensation claim process, in particular the importance of an injury reporting and recording system, the need to report all claims to their insurer, and the importance of immediately directing the injured employee to a high-quality medical provider, supplied by them or their insurer.
- Doctors should understand the critical role they play in workers' compensation, particularly in the determination of causation and promoting return to work. They should also be informed about the fee schedule, treatment guidelines, and how impairment ratings are to be done.
- All stakeholders should be informed about the benefits of returning to work as quickly as possible. Modified and transition-duty employment should be actively promoted by the Division, with metrics that can be tailored to particular stakeholder situations, showing the benefits of such activities. Assistance from the Division should be available to stakeholders, particularly small employers, to help create suitable transition-duty employment.

Mistakes create more work for stakeholders in the system. Education on what is legally required and in the best interest of all stakeholders should reduce mistakes and enhance the self-regulation of the system. Better compliance with law and fewer misunderstandings among the actors in the system would reduce Division workloads.

Expected Outcomes

Expanding education and outreach efforts will result in better-informed stakeholders, leading to fewer disputes, reduced delays in treatment and benefits, and better administrative efficiency. Measurements in this regard will be based not only on broader measures of dispute management, but also on stakeholder feedback reports on customer satisfaction, administrative efficiency, and the availability of assistance and information.

Adjusting the Cap on Benefits for Retirement-Aged Injured Workers

Issue

Under Tennessee law, workers who suffer permanent and total disability are paid a weekly indemnity benefit until the worker reaches Social Security retirement age. An exception to this rule is for workers older than sixty when they suffer injury, whose benefits are paid for a period of two hundred and sixty weeks, or five years. This was based upon a retirement age of sixty-five, which has since been adjusted to up to sixty-seven.

Background

Permanent and total disability benefits expire upon eligibility for full retirement benefits under Social Security.[87] The purpose of Tenn. Code 50-6-207(4)(A)(i) is to guarantee certain workers who suffer injuries after their sixtieth birthday with five years of permanent and total disability benefits. Otherwise, depending on the circumstances of an injured worker's age, only very limited benefits might be paid.

Federal law has changed to adjust the eligibility age for full retirement benefits. If a retiree's birth year is 1937 or earlier, then the "normal retirement age" is 65; if the birth year is 1960 or later, then the normal retirement age is 67. Birth years between 1937 and 1960 have an incrementally increasing retirement age between 65 and 67.

Recommendations

We recommend that Tenn. Code 50-6-207(4)(A)(i) be modified to provide that, with respect to injuries that occur within five years of an injured worker's eligibility for full retirement benefits under the Old Age Insurance Benefit Program, permanent and total disability benefits are payable for 260 weeks.

Expected Outcomes

Adopting this change will result in a permanent and total disability cap that is aligned with the changed Social Security retirement age.

[87] Tenn. Code 50-6-207(4)(B) defines such an injury as one that "totally incapacitates the employee from working at an occupation that brings the employee income."

Improving Research and Metrics

Issue

The Division does not have an internal research and reporting unit. Efforts to develop and track effective metrics are challenging due to antiquated systems. Such measurement systems are extremely helpful, however, in informing stakeholders on system performance and monitoring the success or lack thereof in this reform effort.

Background

A common theme among state workers' compensation administrators, advisory councils, and stakeholder groups is the difficulty in obtaining meaningful research by which to measure system performance. In particular, few states make a concerted effort to track system reforms to see whether the changes have met their objectives or improved performance relative to pre-reform benchmarks.

Many consider Oregon to have an exemplary program of tracking workers' compensation metrics. For example, the "Oregon Study" is perhaps the most well known report containing a national median of workers' compensation premium costs and ranking each state's respective costs against that median. Oregon's Department of Business and Consumer Services publishes numerous other reports relevant to Oregon's workers' compensation system.[88] High-quality reporting practices are developed and managed by experienced and dedicated staff. Equally important are effective data management systems, which combine not only stable technology systems but also consistent and comprehensive data collection.

Tennessee's workers' compensation data systems need updating. The basic system was developed in 1999, and some components do not function as intended, and not all aspects of the Division's functions are included in the system. The Division is in the early stages of a project to upgrade the system, but the current budget for this project was estimated two years ago and may not be sufficient to do accomplish what is needed. The goal of the project is to develop a basic system, which can be expanded over time.[89]

Much of the reporting from the Tennessee Advisory Council on Workers' Compensation is based upon Form SD1, which is a statistical report required to be filed in cases "concluded by settlement" (Tenn. Code 50-6-244(d)). Other forms are used when cases

[88] See http://www4.cbs.state.or.us/ex/imd/external/reports/index.cfm?fuseaction=dir&ItemID=2000.
[89] The Business Solutions Delivery Program in the Tennessee Finance and Administration Department is providing business analyst services to the Division to ensure that the system upgrade project is well defined and well managed.

resolve other than by settlement, or when permanent partial disability is not involved.[90] The SD1 information is used by the Advisory Council and NCCI. The SD1 is not an electronic form, and not all fields are completed on each submitted form, and the information that is provided is not consistently provided. An audit of the accuracy and completeness of SD1 forms submitted would be useful.

The Advisory Council has done a commendable job of assembling an annual report on system benchmarks, but these reports are limited in scope. The Division does not publish reports on system activity or performance. Within the Division, there is no person whose job is devoted to data management or analysis. Reports are created on an as-needed basis by information-technology staff.

Recommendations

We recommend that the Division develop a robust and effective metrics and reporting program. To accomplish this we recommend the following steps:

- Initiate and staff a program dedicated to developing and analyzing appropriate metrics to track program performance. These should be based on well understood and agreed upon key performance indicators. The State of Oregon is a good example to use as a starting point. Ideally this should occur before implementation of reforms. We estimate that a single experienced staff member can initiate this program, with a blend of programming skills, to develop and run appropriate queries, and analytical skills, to validate and analyze results.
- After metrics are identified and confirmed, re-evaluate recent efforts to upgrade the Division's technology systems to confirm that the system will be able to collect and integrate data required to track desired metrics.
- The system upgrade project schedule should continue as rapidly as practicable to ensure that the technology changes are in place before the reforms are implemented. At a minimum, data collection practices should be well understood and modified, as appropriate, before implementing the reforms.
- New methods targeted at collecting feedback from stakeholders should be introduced. Examples would be periodic surveys of more "frequent" stakeholders, like adjusters and attorneys, and customer-service surveys of less "frequent" stakeholders, like injured workers.
- Efforts at regular, relevant stakeholder reporting, based on metrics developed in connection with the reforms, should be increased. These reports should map to key performance indicators.

[90] There is evidence that use of these forms is inconsistent. For example, there are fairly wide data variances between SD1 reports and reports from the Tennessee judiciary on the number of workers' compensation trials.

In the context of the comprehensive reforms encompassed by this report, however, it may be advisable to delay initiating a data and metrics unit at this time until rule making and other internal reorganization plans for the Division are under control. The Division's management has a commendable practice of using data for performance measurement. We presume that management can re-double current efforts to use available data to analyze the progress of reform.

Expected Outcomes

A research capability would provide tremendous assistance to the Division and the Advisory Council in better understanding operations and avoiding, and correcting for, unintended consequences of these reforms.

Summary and Concluding Comments

State workers' compensation systems are routinely modified. In some states the modifications are incremental and merely fine-tune a particular part of the system. Each year a few states take on a comprehensive change of law and this is labeled "reform." The trend of reforms since 2000 has involved efforts to narrow what is covered by workers' compensation and to control medical costs.

Because of more favorable laws on coverage and because of an amazing trend of improvement in compensable injuries, the cost of workers' compensation to employers is as low as it has been in 50 years. Yet, competition within the United States and internationally makes it imperative that Tennessee maintain a favorable cost of employment relative to other jurisdictions. As shown in the Introduction, Tennessee's overall workers' compensation insurance costs have worsened relative to neighboring states.

However, the quality of a workers' compensation system, as well as the business climate in general, should be judged on more than just average insurance rates. Rather, the whole range of benefits, worker satisfaction, ease of claims administration, and compliance costs should also be considered.

To this end, we believe that the recommendations advanced in this report will bring about fundamental changes in Tennessee that will make its system a model for its neighboring states. The recommendations seek to create transparent and fair rules and standards used in administering claims that will make the system far less contentious and far more efficient in moving a claim from first report to final closure. In summary, the recommendations envision a more self-executing and cost-effective system that continue a balanced and equitable workers' compensation program in Tennessee.

The changes in law are comprehensive. Business processes will have to be realigned to adjust to the new rules and new incentives. Some of the more striking of these changes to injured workers, doctors, employers, and insurers include:

- Employers and their insurers must be more careful in the selection of physician panels to offer only providers that clearly consent to treating injured workers from those employers.
- Utilization review must be used more judiciously in light of the presumption of correctness for panel physician treatment plans.
- Medical providers will have an advisory treatment standard that, if followed, creates a presumption of correctness of treatment and validity of services for payment.

- Complaints from injured workers about the handling of their claims will be responded to by ombudsman agents, and most remaining conflicts resolved through mandatory mediation.
- For that small percentage of claims with unresolved disputes, a streamlined and professional system of administrative law will render prompt and consistent interpretations of the law and orders for compliance.

The compensation given for permanent injuries is the most significant indemnity benefit change. We are recommending a system that will greatly improve the certainty and swiftness of PPD benefits, reduce the need to litigate or involve attorneys, and provide a mechanism to more closely match compensation levels with the severity of permanent injury. We are recommending that these changes be made in a cost neutral way, in other words, that weeks of PPD be adjusted so that the aggregate payment for PPD match the current aggregate payment.

Implementing this new system will take hard work by state lawmakers and regulators to frame statutes and rules with clear meaning and practical operation. Establishing consistent and dependable measures to gauge and report outcomes will be vital to avoiding negative unintended consequences. We again caution that the management of the Division will be under great stress and workload-balancing challenges if these reforms are implemented too quickly without proper support. However, if these implementation challenges are met, Tennessee's workers' compensation program will serve its citizens better than any time since it was inaugurated in 1919.

Appendices

APPENDIX I. This appendix provides a summary of the major reform of the Tennessee workers' compensation system that took place in 2004. Also included is a summary of the recent changes in 2012. These summaries are excerpts from the Division, and are available on its website at http://www.tn.gov/labor-wfd/public_info.shtml.

2004 Changes (SB3424/HB3531)

MEDICAL FEE SCHEDULE

The workers' compensation reform legislation provides for a medical fee schedule to apply to all manner of treatment of a work related injury to deliver quality medical care while controlling prices and system costs. The fee schedule is to be effective July 1, 2005. The fee schedule will be developed through consultation with the Medical Care and Cost Containment Committee and the Workers' Compensation Advisory Council and other experts in the medical field. Before adoption the schedule will be reviewed by the House Consumer and Employee Affairs Committee and the Senate Commerce, Labor and Agriculture Committee.

FUTURE MEDICAL BENEFITS

The bill prohibits an employee from selling his/her right to future medical benefits until three years after the date of settlement approval or trial order on injuries to schedule members with a value of 200 weeks or more and to body as whole injuries. The right to future medical benefits for permanent total disability can never be closed. This provision is effective for injuries on or after July 1, 2004. Allows closure of future medical benefits on any schedule member injury for which the injured worker is eligible to receive benefits for a period of less than 200 weeks.

The legislation provides for disputed and controverted claims to be settled as long as the total amount paid is no more than 50 times the minimum weekly benefit rate as of date of the claimed injury. This provision is effective for injuries on or after July 1, 2004. Settlements made pursuit to this section have no right to future medical benefits.

PANEL OF PHYSICIANS

The bill requires the Department of Labor and Workforce Development establish a form for employers to use to provide a panel of physicians. The form requires the employee to document his/her selection of the attending physician by signature and date. The employer must maintain the original form and provide a copy to the employee. The employer is required to provide a copy to the Workers' Compensation Division upon request. This provision is effective for injuries on or after July 1, 2004.

PENALTY FOR UNTIMELY PAYMENT OF TEMPORARY DISABILITY BENFITS

The legislation requires the Department of Labor and Workforce Development to assess

a penalty against an employer, pool or trust, or an employer's insurer who fails to make a payment or who makes an untimely payment of temporary disability benefits to which the injured worker is entitled. The penalty will be assessed when temporary benefits are unpaid or untimely paid 20 or more days after the employer had knowledge of the injury. The penalty amount is 25% of untimely paid or unpaid temporary disability benefits and is made payable to the injured employee. This provision is effective for injuries on or after July 1, 2004.

PERMANENT IMPAIRMENT CAP OF MULTIPLIER FOR IMPAIRMENTS WORTH 200 WEEKS OR MORE

The bill establishes a cap of 1.5 times the permanent impairment rating for claims in which the injured worker returns to work with same employer at same or greater wage. This cap applies to all body as a whole impairments and scheduled member impairments worth 200 weeks or greater. This provision is effective for injuries on or after July 1, 2004.

RECONSIDERATION RIGHTS

Provides for reconsideration of settlements for body as a whole injuries capped at 1.5 if injured employee loses his/her job within 400 weeks of the date of return to work. The reconsideration of settlements for schedule member injuries capped at 1.5 is for the number of weeks the schedule member involved is worth and begins with the day he/she returns to work. The bill provides two exceptions that prohibit an employee from filing for reconsideration: 1. Voluntary resignation or retirement unrelated to the work-related disability. 2. Employee misconduct. The bill retains the six times cap on non-return to work permanent partial disability settlements on body as a whole injuries and also applies this six times cap on non return to work permanent partial disability settlements for scheduled members worth 200 weeks or more. Clarifies that employees are not permitted to waive or forfeit and the parties are not permitted to compromise and settle, the employee's rights to reconsideration. These provisions are effective for injuries which occur on or after July 1, 2004.

IMPAIRMENT RATING GUIDELINES

The legislation requires physicians to use the applicable edition of the AMA Guides to Permanent Impairment. In cases not covered by the AMA Guides, an impairment rating by any appropriate method used and accepted by the medial community is allowed. The division Administrator determines which edition is applicable. The full title of the most recent edition and the date it became effective will be maintained on the website of the Tennessee Workers' Compensation Division (www.state.tn.us/labor-wfd/wcomp.html). This provision is effective for injuries which occur on or after July 1, 2004.

BENEFIT REVIEW CONFERENCE PROCESS

The bill prohibits filing a case in court until after the Benefit Review Conference process has been exhausted. If a date for a conference is not agreed upon within 45 days of request or date of maximum medical improvement, the Workers' Compensation Division will set the date of the Benefit Review Conference. If the Division fails to conduct the Benefit Review Conference within 60 days, the parties may elect, at their own expense, to hire a private Rule 31 mediator to conduct a mediation conference. Any agreement reached through private mediation must be approved by either the department or a court. There is an exception for cases in which there is no dispute and parties reach a settlement without the need for a Benefit Review Conference. In these settlements the parties can proceed to court or to the division for approval. These provisions are effective for injuries which occur on or after January 1, 2005.

AUTHORITY TO CONTINUE, WAIVE OR DISMISS A BENEFIT REVIEW CONFERENCE The legislation gives authority to the Workers' Compensation Specialist, within their sole discretion, to continue, waive or dismiss a Benefit Review Conference. This provision is effective for injuries which occur on or after January 1, 2005.

ELIMINATION OF CRIMINAL COURT JURISDICTION TO HEAR WORKERS' COMPENSATION CASES The bill eliminates criminal court jurisdiction to hear workers' compensation cases. This provision is effective July 1, 2004.

TEMPORARY AND PERMANENT DISABILITY BENEFIT CAPS

The legislation raises the cap on weekly temporary disability benefits to 105% of the state's average weekly wage for injuries which occur on July 1, 2004 through June 30, 2005. It raises cap on compensation benefits in temporary cases only to 110% of the state's average weekly wage for injuries which occur on July 1, 2005. The cap on permanent partial benefits remains at 100% of the state's average weekly wage.

INDEPENDENT MEDICAL EXAMINATION REGISTRY

The bill establishes an Independent Medical Examination Registry to settle disputes as to an injured worker's impairment rating. The opinion of the physician selected through the Registry process shall be presumed to be accurate and can only be rebutted by clear and convincing evidence. Independent medical examinations are paid for by the employer or insurer. No physician may serve as an independent medical examiner in a case where that physician was listed on the panel provided to the employee to chose his/her treating physician. This provision is effective for injuries which occur on or after July 1, 2005.

SECOND INJURY FUND

Limits Second Injury Fund exposure to permanent total cases only and applies to injuries which occur on or after July 1, 2005.

CASE MANAGEMENT

Case Management is no longer mandatory and if utilized it is at the employer's expense and the employee must cooperate. This provision is effective July 1, 2004.

WORKERS' COMPENSATION ADVISORY COUNCIL REVIEW REQUIREMENTS The bill requires the Workers' Compensation Advisory Council to review restrictions on employee's choice of treating physician, review definition of "injury", and review replacing present workers' compensation system with an administrative commission or review board. The Council will also study occupational health and safety in Tennessee's workplaces. The bill requires the Council to include in the annual report significant workers' compensation court decisions and a breakdown of awards by judicial districts. Standing committees of the General Assembly may refer workers' compensation bills to the Council for comment.

JUDICIAL TRAINING

This legislation requires judicial training on workers' compensation laws, requirements, and procedures and the use of the AMA Guides to be provided by the Administrative Office of the Courts effective July 1, 2004.

MEDICAL CARE AND COST CONTAINMENT COMMITTEE

The Medical Care and Cost Containment Committee's composition will increase from 8 to 14 members. New members consist of 1 additional member from the Tennessee AFL-CIO, 2 additional members from the Tennessee Hospital Association, 1 additional member from the Tennessee Chamber of Commerce and Industry, 1 new member from the Tennessee Pharmacists Association, and 1 new member from the health insurance industry. This provision is effective July 1, 2004.

DEPARTMENT OF COMMERCE AND INSURANCE – SELF INSURED EMPLOYER BONDS AND FINANCIAL STATEMENTS The minimum bond amount required by the Department of Commerce and Insurance from a single self-insured employer is $500,000.00. This section of the bill sets forth certain requirements for deposits of negotiable securities, certificates of deposit, letters of credit and bonds filed by a self-insurance with the Department of Commerce and Insurance. Financial statements required to be filed biennially with the Department of Commerce and Insurance must be actuarially certified. This provision is effective January 1, 2005.

The Department of Commerce and Insurance may assess a civil penalty of $100 per day against a single self-insured employer for each day that it fails to provide its financial statement. The bill provides that a single self-insured employer must have a certificate of authority issued by the Department of Commerce and Insurance before it may transact business as a self-insurer. The Commissioner of Commerce and Insurance has the authority to conduct examinations and investigations of singe self-insured

employers necessary for the protection of the public. The Commissioner of Commerce and Insurance is also authorized to examine the financial condition of all employers who are self-insured or members of a self-insured pool or trust. These provisions are effective January 1, 2005.

DEPARTMENT OF COMMERCE AND INSURANCE – UNFAIR COMPETITION AND DECEPTIVE ACTS The bill expands the power of the Department of Commerce and Insurance to regulate "unfair competition and deceptive acts" to include self-insured employers or members of a self-insured pool or trust. This provision is effective July 1, 2004.

DEPARTMENT OF COMMERCE AND INSURANCE – UNTIMELY PAYMENT OF WORKERS COMPENSATION BENEFITS IS UNFAIR CLAIM SETTLEMENT PRACTICE The bill makes the general practice of failing to make timely payment of workers' compensation benefits an unfair claim settlement practice subject to the Department of Commerce and Insurance's enforcement powers. This provision is effective July 1, 2004.

APPENDIX II. Modifying the "Liberal Construction" Interpretation

This appendix contains the relevant state statutory language from Tennessee and California (examples of states with statutory requirement of "liberal" or "equitable" construction) and from Arkansas, Florida, Kansas, Louisiana, Mississippi, Missouri, New Mexico, and West Virginia (examples of states with statutory requirement of "neutral" or "on the merits" construction. Also included in an excerpt on Iowa's interpretive principle. The text below is largely quoted from statutes, but because some paraphrasing and selection was done, quotation marks were omitted.

Tennessee

Tenn. Code 50-6-116

The rule of common law requiring strict construction of statutes in derogation of common law shall not be applicable to this chapter, but this chapter is declared to be a remedial statute, which shall be given an equitable construction by the courts, to the end that the objects and purposes of this chapter may be realized and attained.

California

Cal. Lab. Code 3202

This division and Division 5 (commencing with Section 6300) shall be liberally construed by the courts with the purpose of extending their benefits for the protection of persons injured in the course of their employment.

Arkansas (enacted 1993)

Ark. Code 11-9-1001

The Seventy-Ninth General Assembly realizes that the Arkansas workers' compensation statutes must be revised and amended from time to time. Unfortunately, many of the changes made by this act were necessary because administrative law judges, the Workers' Compensation Commission, and the Arkansas courts have continually broadened the scope and eroded the purpose of the workers' compensation statutes of this state. The Seventy-Ninth General Assembly intends to restate that the major and controlling purpose of workers' compensation is to pay timely temporary and permanent disability benefits to all legitimately injured workers that suffer an injury or disease arising out of and in the course of their employment, to pay reasonable and necessary medical expenses resulting therefrom, and then to return the worker to the work force. When, and if, the workers' compensation statutes of this state need to be changed, the General Assembly acknowledges its responsibility to do so. It is the specific intent of the Seventy-Ninth General Assembly to repeal, annul, and hold for naught all prior opinions or decisions of any administrative law judge, the Workers' Compensation Commission, or courts of this state contrary to or in conflict with any provision in this act. In the future, if such things as the statute of limitations, the standard of review by the Workers' Compensation Commission or courts, the extent to which any physical condition, injury, or disease should be excluded from or added to coverage by the law, or the scope of the workers' compensation statutes need to be liberalized, broadened, or narrowed, those things shall be addressed by the General Assembly and should not be done by administrative law judges, the Workers' Compensation Commission, or the courts.

Florida (enacted 2003)

Fla. Stat. 440.015

It is the intent of the Legislature that the Workers' Compensation Law be interpreted so as to assure the quick and efficient delivery of disability and medical benefits to an injured worker and to facilitate the worker's return to gainful reemployment at a reasonable cost to the employer. It is the specific intent of the Legislature that workers' compensation cases shall be decided on their merits. The workers' compensation system in Florida is based on a mutual renunciation of common-law rights and defenses by employers and employees alike. In addition, it is the intent of the Legislature that the

facts in a workers' compensation case are not to be interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. Additionally, the Legislature hereby declares that disputes concerning the facts in workers' compensation cases are not to be given a broad liberal construction in favor of the employee on the one hand or of the employer on the other hand, and the laws pertaining to workers' compensation are to be construed in accordance with the basic principles of statutory construction and not liberally in favor of either employee or employer. It is the intent of the Legislature to ensure the prompt delivery of benefits to the injured worker. Therefore, an efficient and self-executing system must be created which is not an economic or administrative burden. The department, agency, the Office of Insurance Regulation, the Department of Education, and the Division of Administrative Hearings shall administer the Workers' Compensation Law in a manner which facilitates the self-execution of the system and the process of ensuring a prompt and cost-effective delivery of payments.

Kansas (enacted 2011)

Kan. Stat. 44-501b(a)

It is the intent of the legislature that the workers compensation act shall be liberally construed only for the purpose of bringing employers and employees within the provisions of the act. The provisions of the workers compensation act shall be applied impartially to both employers and employees in cases arising thereunder.

Louisiana (enacted 2012)

La. Stat. 23:1020.1(D)

Disputes concerning the facts in workers' compensation cases shall not be given a broad, liberal construction in favor of either employees or employers; the laws pertaining to workers' compensation shall be construed in accordance with the basic principles of statutory construction and not in favor of either employer or employee.

Mississippi (enacted 2012)

Miss. Code 71-3-1

This chapter shall be known and cited as "Workers' Compensation Law," and shall be administered by the Workers' Compensation Commission, hereinafter referred to as the "commission," cooperating with other state and federal authorities for the prevention of injuries and occupational diseases to workers and, in event of injury or occupational

disease, their rehabilitation or restoration to health and vocational opportunity; and this chapter shall be fairly and impartially construed and applied according to the law and the evidence in the record, and, notwithstanding any common law or case law to the contrary, this chapter shall not be presumed to favor one party over another and shall not be liberally construed in order to fulfill any beneficent purposes.

Missouri (enacted 2005)

Mo. Stat. 287.800

1. Administrative law judges, associate administrative law judges, legal advisors, the labor and industrial relations commission, the division of workers' compensation, and any reviewing courts shall construe the provisions of this chapter strictly.

2. Administrative law judges, associate administrative law judges, legal advisors, the labor and industrial relations commission, and the division of workers' compensation shall weigh the evidence impartially without giving the benefit of the doubt to any party when weighing evidence and resolving factual conflicts.

New Mexico (enacted 1990)

N.M. Stat. 52-5-1

It is the intent of the legislature in creating the workers' compensation administration that the laws administered by it to provide a workers' benefit system be interpreted to assure the quick and efficient delivery of indemnity and medical benefits to injured and disabled workers at a reasonable cost to the employers who are subject to the provisions of the Workers' Compensation Act [Chapter 52, Article 1 NMSA 1978] and the New Mexico Occupational Disease Disablement Law [52-3-1 NMSA 1978]. It is the specific intent of the legislature that benefit claims cases be decided on their merits and that the common law rule of "liberal construction" based on the supposed "remedial" basis of workers' benefits legislation shall not apply in these cases. The workers' benefit system in New Mexico is based on a mutual renunciation of common law rights and defenses by employers and employees alike. Accordingly, the legislature declares that the Workers' Compensation Act and the New Mexico Occupational Disease Disablement Law are not remedial in any sense and are not to be given a broad liberal construction in favor of the claimant or employee on the one hand, nor are the rights and interests of the employer to be favored over those of the employee on the other hand.

West Virginia (enacted 2003)

W. Va. Code 23-1-1(b)

It is the further intent of the Legislature that this chapter be interpreted so as to assure the quick and efficient delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of this chapter. It is the specific intent of the Legislature that workers' compensation cases shall be decided on their merits and that a rule of "liberal construction" based on any "remedial" basis of workers' compensation legislation shall not affect the weighing of evidence in resolving such cases. The workers' compensation system in this state is based on a mutual renunciation of common law rights and defenses by employers and employees alike. Employees' rights to sue for damages over and above medical and health care benefits and wage loss benefits are to a certain degree limited by the provisions of this chapter and employers' rights to raise common law defenses, such as lack of negligence, contributory negligence on the part of the employee, and others, are curtailed as well. Accordingly, the Legislature hereby declares that any remedial component of the workers' compensation laws is not to cause the workers' compensation laws to receive liberal construction that alters in any way the proper weighing of evidence as required by section one-g, article four of this chapter.

Iowa (common law)

Excerpted from: Boulton, N., *Establishing Causation in Iowa Workers' Compensation Law: An Analysis Of Common Disputes Over The Compensability Of Certain Injuries*, 463 *Drake Law Rev*. 59, p. 465-66 (2011) (footnotes omitted).

Our courts have long held the Iowa Workers' Compensation Act was drafted for the benefit of injured workers and should be liberally construed to further that objective. This policy has been in place since the *Pierce v. Bekins Van & Storage Co.* decision in 1919, when the court held that because of its remedial nature, the Iowa workers' compensation statute "shall have a broad and liberal construction in aid of accomplishing the object of the enactment." "In construing the provisions of the Compensation Law the court is bound, not to a narrow, technical construction, but rather to a broad and liberal construction to make effectual the very purposes for which the law was passed." The court has also held the Act "is to be liberally construed so as to get within the spirit rather than only within the letter of the law." Liberal interpretation of Iowa's workers' compensation laws is necessary because the Act was originally implemented for the benefit of injured workers and their dependents, and the courts are bound to help realize that objective in their application of the Act and in resolution of legal questions related to it. The Iowa Workers' Compensation Act is elastic in nature, as it stretches to allow inclusion of various types of injuries and recoveries to maximize the protections the Act affords injured workers.

APPENDIX III. Setting a Clearer Standard for Causation

This appendix contains examples of state workers' compensation statutes intending to provide for a narrow interpretation of causation. Included are older examples from Oregon and Florida as well as more recent examples from Kansas, Missouri and Oklahoma. Again, for the most part these are direct quotations from statute, but there are some edits to simplify text for this summary.

Oregon (as amended; originally enacted 1990)

Or. Stat. 656.005(7)(a). *Definitions*

A compensable injury is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:

(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition.

(B) If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition.

Florida (enacted 2003)

Fla. Stat. 440.09(1)(a) & (b)

(1) The employer must pay compensation or furnish benefits required by this chapter if the employee suffers an accidental compensable injury or death arising out of work performed in the course and the scope of employment. The injury, its occupational cause, and any resulting manifestations or disability must be established to a reasonable degree of medical certainty, based on objective relevant medical findings, and the accidental compensable injury must be the major contributing cause of any resulting injuries. For purposes of this section, "major contributing cause" means the cause which is more than 50 percent responsible for the injury as compared to all other causes combined for which treatment or benefits are sought. In cases involving occupational

disease or repetitive exposure, both causation and sufficient exposure to support causation must be proven by clear and convincing evidence. Pain or other subjective complaints alone, in the absence of objective relevant medical findings, are not compensable. For purposes of this section, “objective relevant medical findings” are those objective findings that correlate to the subjective complaints of the injured employee and are confirmed by physical examination findings or diagnostic testing. Establishment of the causal relationship between a compensable accident and injuries for conditions that are not readily observable must be by medical evidence only, as demonstrated by physical examination findings or diagnostic testing. Major contributing cause must be demonstrated by medical evidence only.

(a) This chapter does not require any compensation or benefits for any subsequent injury the employee suffers as a result of an original injury arising out of and in the course of employment unless the original injury is the major contributing cause of the subsequent injury. Major contributing cause must be demonstrated by medical evidence only.

(b) If an injury arising out of and in the course of employment combines with a preexisting disease or condition to cause or prolong disability or need for treatment, the employer must pay compensation or benefits required by this chapter only to the extent that the injury arising out of and in the course of employment is and remains more than 50 percent responsible for the injury as compared to all other causes combined and thereafter remains the major contributing cause of the disability or need for treatment. Major contributing cause must be demonstrated by medical evidence only.

Kansas (enacted 2011)

Kan. Stat. 44-508

(d) ‘‘Accident’’ means an undesigned, sudden and unexpected traumatic event, usually of an afflictive or unfortunate nature and often, but not necessarily, accompanied by a manifestation of force. An accident shall be identifiable by time and place of occurrence, produce at the time symptoms of an injury, and occur during a single work shift. The accident must be the prevailing factor in causing the injury. ‘‘Accident’’ shall in no case be construed to include repetitive trauma in any form.

(e) ‘‘Repetitive trauma’’ refers to cases where an injury occurs as a result of repetitive use, cumulative traumas or microtraumas. The repetitive nature of the injury must be demonstrated by diagnostic or clinical tests. The repetitive trauma must be the prevailing factor in causing the injury. ‘‘Repetitive trauma’’ shall in no case be construed to include occupational disease, as defined in K.S.A. 44-5a01, and amendments thereto. In the case of injury by repetitive trauma, the date of injury shall be the earliest of:
(1) The date the employee, while employed for the employer against whom benefits are

sought, is taken off work by a physician due to the diagnosed repetitive trauma;
(2) the date the employee, while employed for the employer against whom benefits are sought, is placed on modified or restricted duty by a physician due to the diagnosed repetitive trauma;
(3) the date the employee, while employed for the employer against whom benefits are sought, is advised by a physician that the condition is work-related; or
(4) the last day worked, if the employee no longer works for the employer against whom benefits are sought.
In no case shall the date of accident be later than the last date worked.

(f) (1) ‘‘Personal injury’’ and ‘‘injury’’ mean any lesion or change in the physical structure of the body, causing damage or harm thereto. Personal injury or injury may occur only by accident, repetitive trauma or occupational disease as those terms are defined.
(2) An injury is compensable only if it arises out of and in the course of employment. An injury is not compensable because work was a triggering or precipitating factor. An injury is not compensable solely because it aggravates, accelerates or exacerbates a preexisting condition or renders a preexisting condition symptomatic.
(A) An injury by repetitive trauma shall be deemed to arise out of employment only if:
(i) The employment exposed the worker to an increased risk or hazard which the worker would not have been exposed in normal non-employment life;
(ii) the increased risk or hazard to which the employment exposed the worker is the prevailing factor in causing the repetitive trauma; and
(iii) the repetitive trauma is the prevailing factor in causing both the medical condition and resulting disability or impairment.
(B) An injury by accident shall be deemed to arise out of employment only if:
(i) There is a causal connection between the conditions under which the work is required to be performed and the resulting accident; and
(ii) the accident is the prevailing factor causing the injury, medical condition, and resulting disability or impairment.
(3) (A) The words ‘‘arising out of and in the course of employment’’ as used in the workers compensation act shall not be construed to include: (i) Injury which occurred as a result of the natural aging process or by
the normal activities of day-to-day living; (ii) accident or injury which arose out of a neutral risk with no particular employment or personal character; (iii) accident or injury which arose out of a risk personal to the worker; or (iv) accident or injury which arose either directly or indirectly from idiopathic causes.
(B) The words ‘‘arising out of and in the course of employment’’ as used in the workers compensation act shall not be construed to include injuries to the employee occurring while the employee is on the way to assume the duties of employment or after leaving such duties, the proximate cause of which injury is not the employer’s negligence. An employee shall not be construed as being on the way to assume the duties of employment or having left such duties at a time when the worker is on the premises owned or under the exclusive control of the employer or on the only avail- able route to or from work which is a route involving a special risk or hazard connected with the

nature of the employment that is not a risk or hazard to which the general public is exposed and which is a route not used by the public except in dealings with the employer. An employee shall not be construed as being on the way to assume the duties of employment, if the employee is a provider of emergency services responding to an emergency.
(C) The words, ‘‘arising out of and in the course of employment’’ as used in the workers compensation act shall not be construed to include injuries to employees while engaged in recreational or social events under circumstances where the employee was under no duty to attend and where the injury did not result from the performance of tasks related to the employee’ s normal job duties or as specifically instructed to be performed by the employer .

(g) ‘‘Prevailing’’ as it relates to the term ‘‘factor’’ means the primary factor, in relation to any other factor. In determining what constitutes the ‘‘prevailing factor’’ in a given case, the administrative law judge shall consider all relevant evidence submitted by the parties.

(h) ‘‘Burden of proof’’ means the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party’s position on an issue is more probably true than not true on the basis of the whole record unless a higher burden of proof is specifically required by this act.

Oklahoma (enacted 2011)

Ok. Stat 85-308(10)

a. "Compensable injury" means any injury or occupational illness, causing internal or external harm to the body, which arises out of and in the course of employment if such employment was the major cause of the specific injury or illness. An injury, other than cumulative trauma, is compensable only if it is caused by a specific incident and is identifiable by time, place and occurrence unless it is otherwise defined as compensable in this act. A compensable injury must be established by objective medical evidence. The employee has the burden of proof to establish by a preponderance of the evidence that such unexpected or unforeseen injury was in fact caused by the employment. There is no presumption from the mere occurrence of such unexpected or unforeseen injury that the injury was in fact caused by the employment.

b. "Compensable injury" means a cardiovascular, coronary, pulmonary, respiratory, or cerebrovascular accident or myocardial infarction causing injury, illness, or death, only if, in relation to other factors contributing to the physical harm, a work-related activity is the major cause of the physical harm. Such injury shall not be deemed to be a compensable injury unless it is shown that the exertion of the work necessary to precipitate the disability or death was extraordinary and unusual in comparison to the

usual work of the employee, or alternately, that some unusual incident occurred which is found to have been the major cause of the physical harm.

c. "Compensable injury" shall not include the ordinary, gradual deterioration or progressive degeneration caused by the aging process, unless the employment is a major cause of the deterioration or degeneration and is supported by objective medical evidence; nor shall it include injury incurred while engaging in or performing, or as the result of engaging in or performing, any recreational or social activities.

d. "Compensable injury" includes personal property which is established by objective medical evidence to be medically necessary and which replaces or improves normal physical function of the body, such as artificial dentures, artificial limbs, glass eyes, eye glasses and other prostheses which are placed in or on the body and is damaged as a result of the injury.

e. "Compensable injury" shall not include an injury resulting directly or indirectly from idiopathic causes; any contagious or infectious disease unless it arises out of and occurs in the scope and course of employment; or death due to natural causes occurring while the worker is at work.

f. "Compensable injury" shall not include mental injury that does not arise directly as a result of a compensable physical injury, except in the case of rape or other crime of violence which arises out of and in the course of employment.

Missouri (enacted 2005)

Mo. Stat. 287.020.3

(1) In this chapter the term "injury" is hereby defined to be an injury which has arisen out of and in the course of employment. An injury by accident is compensable only if the accident was the prevailing factor in causing both the resulting medical condition and disability. "The prevailing factor" is defined to be the primary factor, in relation to any other factor, causing both the resulting medical condition and disability.

(2) An injury shall be deemed to arise out of and in the course of the employment only if:
(a) It is reasonably apparent, upon consideration of all the circumstances, that the accident is the prevailing factor in causing the injury; and
(b) It does not come from a hazard or risk unrelated to the employment to which workers would have been equally exposed outside of and unrelated to the employment in normal nonemployment life.

(3) An injury resulting directly or indirectly from idiopathic causes is not compensable.

(4) A cardiovascular, pulmonary, respiratory, or other disease, or cerebrovascular accident or myocardial infarction suffered by a worker is an injury only if the accident is the prevailing factor in causing the resulting medical condition.

(5) The terms "injury" and "personal injuries" shall mean violence to the physical structure of the body and to the personal property which is used to make up the physical structure of the body, such as artificial dentures, artificial limbs, glass eyes, eyeglasses, and other prostheses which are placed in or on the body to replace the physical structure and such disease or infection as naturally results therefrom. These terms shall in no case except as specifically provided in this chapter be construed to include occupational disease in any form, nor shall they be construed to include any contagious or infectious disease contracted during the course of the employment, nor shall they include death due to natural causes occurring while the worker is at work.

APPENDIX IV. This appendix provides a regional summary of system structures and funding. Next it provides additional detail on the recommended implementation of the administrative model. This includes the mediation and hearing models. Also provided are examples of a similar structure in Montana, a relevant structure in Oklahoma, some relevant hearing provisions from Missouri, as well as an example of a mediation program in Arkansas.

Summary of Hearing Resolution Structures – Tennessee and Neighboring States

Source: *2012 Analysis of Workers' Compensation Laws*, p. 87-102, 115-124 (U.S. Chamber of Commerce) ("Workers' compensation laws generally are administered by commissions or boards created by law. A few states provide for court administration.")

State	Hearing Administration	Agency Review	First Appeal/ Final Appeal	Funding
Alabama	Court	NA	Court of Civil Appeals/Supreme Court	% of claims
Arkansas	Commission	Full Commission	Court of Appeals/Supreme Court	Up to 3%

Georgia	Board	Board Appellate Division	Superior Court/Court of Appeals	Prorated amount
Kentucky	Department	Workers' Compensation Board	Court of Appeals/Supreme Court	6%
Mississippi	Commission	Commission	Circuit Court/Court of Appeals/Supreme Court	Prorated amount
Missouri	Division	Industrial Commission	Appellate Court	Up to 2% plus add'l up to 2%
North Carolina	Commission	Deputy Commissioner; Full Commission	Court of Appeals	% of net premiums
Virginia	Commission	Full Commission	Court of Appeals/Supreme Court	2.5%
Tennessee	Courts (there are mandatory RFA & BRC processes)	NA	WC Panel/Supreme Court	4%

Details of the Recommended Dispute System

Hearings – Workers' Compensation Judge

The details regarding such reform include the manner by which hearings are conducted, reviewed and appealed.

The "Workers' Compensation Judge" approach would involve:

1. Appointment of "Workers' Compensation Judges," ("WCJs") adequate to process the caseload without delay, must occur on the basis of substantive expertise and not of political or philosophical leanings.
    a. As political influences potentially inject variability and uncertainty into the system, it is recommended that the appointments be made by the Director of the Tennessee Workers' Compensation Division pursuant to stated criteria, and that there be no political oversight or confirmation in the process.
    b. Since it is inevitable that the employer's or worker's sides of disputes will regard some hearing officers as "more neutral" than others, a mechanism for preemptory disqualification of WCJs would be advisable, but only in

the case of "clear evidence" of a conflict or failure to perform as a "neutral."

c. WCJs shall serve for a term of years, but shall be subject to early termination for malfeasance or nonfeasance of duty.
d. WCJs shall adhere to the canon of judicial ethics for Tennessee judges, and follow the rules of conduct and procedure as established by the Division.

2. WCJs shall conduct hearings as follows:
    a. The standard for admission of evidence shall be that any credible evidence may be admitted "for what it is worth" and that the formal rules of evidence do not apply. The Commissioners would create rules of procedure and discovery designed to provide fair notice of the matters to be heard and an opportunity to confront witnesses. Testimony by treating and reviewing physicians shall be accepted in the form of depositions, and signed reports of health care providers and allied health professionals in recognized specialties shall be admissible, "for what they are worth."
    b. The Deputies are authorized to enter orders adopting findings of fact and conclusions of law. They are authorized to compel attendance of witnesses, take sworn testimony and maintain the dignity and order of their hearings, provided however, that any sanctions for disobedience of lawful orders shall be reviewed and confirmed by the Commission before imposed.
    c. Any party may seek a review of a Deputy's order by appeal to the full Commission.
    d. It would be beneficial to establish a special expedited hearing process (Often called a "rocket docket" in states that use the feature) to hear matters involving the choice of health care providers, application of the permanent impairment formula, and other similar issues. These matters are often the only dispute that an injured worker will have in their case, and it is beneficial to avoid forcing them to engage an attorney to conduct the hearing, because of the cost of the attorney representation (or its availability) in light of the small economic value of the dispute. As a result, special attention should be given to allowing relaxed rules of evidence and hearing formalities, permitting *pro se* workers the opportunity to be heard.
3. Initial review of the WCJ's order shall be by random selection of a reviewer from the Administrative Review Panel. ("Review Judge") This individual must have been involved in any proceedings with respect to the same issue and same litigants.
    a. The Review Judge shall review the record and findings of fact and conclusions of law of the WCJ and may conduct additional hearings to clarify issues raised by the record or the parties. The Review Judge shall confirm the WCJs order or remand the order to the WCJ for further

proceedings, but shall disturb the WCJs findings of fact only upon a finding that they are arbitrary or capricious or against the clear weight of the evidence.

   b. The review and order confirming or remanding shall be summary in nature and must be completed within 7 days. If remanded, the case returns to the WCJ for further proceedings.

4. The UAPA shall not apply to workers' compensation proceedings or promulgation of rules and regulations by the Division for such proceedings.
5. If after review the WCJ decision is confirmed, appeal shall be to the Special Workers' Compensation Appeals Panel of the Tennessee Supreme Court. Appeals shall proceed as a matter of right, under procedures applicable to other civil appellate matters.
   a. The Special Appeals Panel shall not disturb the findings of fact of the WCJ nor his or her weighing of the evidence, absent a finding that the WCJ has acted in a manner that is arbitrary, capricious or abusive of discretion in their adoption. Upon such a finding the Special Appeals Panel shall remand the matter to the Division for further proceedings.
   b. The Special Appeals Panel shall issue opinions resolving the appeal, or remanding or further proceedings, subject to the limitations in its jurisdiction, but otherwise in the manner of other civil appellate proceedings.
6. Appeal from the Special Appeals Panel shall be at the discretion of the Tennessee Supreme Court.

Mediation

It is would be critical to provide for a robust pre-litigation dispute resolution process that would encourage the parties to resolve issues at the lowest possible level of formality, cost and delay.[91] The first step in this process would include an Ombudsman program, as described in another recommendation. The second step would involve a mediation program:

Mediation program (mandatory option)[92]

[91] The Arkansas mediation program is a combined Ombudsman and mediation program. A "Legal Advisor" performs both functions. It is mandatory for all cases where the amount in dispute is less than $2,500, and otherwise voluntary. The program results in over 90% of claims resolved before formal hearing. During the latest reported three-year period, the resolution rate before formal hearing was 90.5% (2009), 91.7% (2010) and 92.1% (2011). There are, however, relatively few mediations conducted, with the total numbers for those years at 75, 41 and 91 respectively. This reflects the effectiveness of the ombudsman component of their services, and also reflects the additional potential for avoidance of litigation in the creation of a separate mediation function, as we have recommended. This level of outcome was accomplished with four lawyer staff members.

[92] Mediation program (voluntary option)

a. Every case that has been filed with DOL shall be submitted for "mediation" as a procedural predicate to subsequent proceedings before DOL.
b. A mediation hearing shall be scheduled as quickly as practicable after the filing of an RFA. (An RFA will be filed any time a party seeks relief on an issue, including compensability, treatment, and benefits, both temporary and permanent. We recommend consolidating all such requests, whether RFA or BRC, into a single format.) The attendance of the worker, a representative of the employer in the worker's chain of command and a representative of the insurer possessing settlement authority on the case shall be mandatory
c. The hearing shall be conducted by a mediator, employed by DOL, who is learned in Tennessee workers' compensation law.
d. The Division Administrator may, by regulation, require minimal mandatory submissions with respect to any dispute and provide for pre-hearing exchange of evidence and statements of issues and positions.
e. The rules of evidence shall not apply to mediation hearings and the proceedings shall be informal in nature.
f. The purpose of mediation is to:
    i. Assist the parties in coming to a voluntary agreement resolving the matter and documenting that agreement; or, if agreement cannot be reached,
    ii. Recommend to the parties the best judgment of the mediator as to how the case would be resolved if the matter were to be fully resolved in court; and
    iii. Narrow, by agreement, the issues that remain in dispute and are subject to further proceedings.
g. The mediator shall issue a Dispute Certification, containing
    i. The agreement of the parties resolving the matters brought to the mediation, if such agreement has been achieved, or

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a. Either party to a case that has been filed with DOL may request mediation of the matter. If the other party does not agree, mediation shall not proceed.
b. Mediation may run as a parallel process to existing dispute resolution proceedings
c. The parties may use any mediator selected by mutual agreement, and DOL will provide the services of trained mediators without charge to the parties in dispute. If a private mediator is utilized, the costs of the mediation will be evenly shared by the parties, unless otherwise agreed.
d. The mediator will attempt to facilitate a mutual agreement for the resolution of all or part of the dispute and for the narrowing of issues for formal processing.
e. If an agreement is reached, the mediator will produce a written document memorializing the agreement and submit it for the signatures of both parties. A mediation agreement that has been signed by both parties and filed with DOL shall be considered the law of the case, and the matters resolved shall not be disturbed, absent a showing by clear and convincing evidence of misrepresentation, failure to disclose relevant information, or change in condition that could not be reasonably anticipated.

ii. Any agreements reached regarding resolution or narrowing of issues[93];
iii. The parties shall be provided with an official copy of the Dispute Certification and shall respond to it within 15 working days. Failure to timely respond with out adequate justification shall result in a deemed acceptance of the Dispute Certification.
iv. Any party that contests any provision of the Dispute Certification shall provide to the opposing party and DOL a written response detailing the portion(s) objected to and the reasons of the objection. Filing of a written objection to the Dispute Certification shall be a condition precedent for formal dispute resolution.
v. If neither party file a timely written response objecting to the Dispute Certification it shall be given the force of law and become the law of the case.

Sanctions for non-compliance with informal dispute resolution

a. It shall be the duty of every party and service provider to comply with the mandatory provisions of the ombudsman and mediation provisions, and to reasonably cooperate with ombudsmen and mediators.
b. The Commissioner may, after notice and an opportunity to be heard, impose sanctions for any violation of the duty to comply and cooperate with the ombudsman and mediation processes demonstrated by clear and convincing evidence. The sanctions available for imposition shall include economic sanctions, and equitable relief reasonably designed to restore the parties to their status prior to the violation of duty and deter future violations. Any economic sanctions shall be paid to a fund used to facilitate public education regarding the workers' compensation laws of Tennessee. The provisions of the UAPA shall not apply. Parties aggrieved of the actions of the Division Administrator pursuant to this paragraph may seek a remedy by way of writ of mandamus or prohibition, pursuant to the applicable rules of appellate procedure.
c. The Division Administrator may employ investigators for the purpose of investigating violations of this paragraph.

Relevant Montana Statutory Provisions

[93] We would also recommend that the Dispute Certification contain a suggestion by the mediator as to the merits of the dispute. This is optional, and depends on the particular approach selected for the Mediation program and the training and experience of the Mediators.

In Montana, the workers' compensation department conducts hearings and is the primary body for resolving disputes. Appeals from decisions are to a workers' compensation judge. Mediation is also mandatory.

Mont. Code 39-71-203. Powers of department -- rules. (1) The department is hereby vested with full power, authority, and jurisdiction to do and perform any and all things that are necessary or convenient in the exercise of any power, authority, or jurisdiction conferred upon it under this chapter.

(2) The department may adopt rules to carry out the provisions of this chapter.

39-71-204. Hearings -- rules of evidence -- appeal, rescission, alteration, or amendment by department of its orders, decisions, or awards -- effect -- appeal. (1) The statutory and common-law rules of evidence do not apply to a hearing before the department under this chapter. A petition for a hearing before the department must be filed within 2 years after benefits are denied.

(2) A hearing under this chapter may be conducted by telephone or by videoconference.

(3) The department has continuing jurisdiction over all its orders, decisions, and awards and may, at any time, upon notice, and after opportunity to be heard is given to the parties in interest, rescind, alter, or amend any order, decision, or award made by it upon good cause.

(4) Any order, decision, or award rescinding, altering, or amending a prior order, decision, or award has the same effect as original orders or awards.

(5) If a party is aggrieved by a department order, the party may appeal the dispute to the workers' compensation judge.

39-71-2901. Location of office -- court powers -- withdrawal -- substitution. (1) The principal office of the workers' compensation judge must be in the city of Helena.

(2) The workers' compensation court has power to:

(a) preserve and enforce order in its immediate presence;

(b) provide for the orderly conduct of proceedings before it and its officers;

(c) compel obedience to its judgments, orders, and process in the same manner and by the same procedures as in civil actions in district court;

(d) compel the attendance of persons to testify; and

(e) punish for contempt in the same manner and by the same procedures as in district court.

(3) The workers' compensation judge shall withdraw from all or part of any matter if the judge believes the circumstances make disqualification appropriate. In the case of a withdrawal, the workers' compensation judge shall designate and contract for a substitute workers' compensation judge to preside over the proceeding from the list provided for in subsection (4). The substitute judge must be compensated at the same hourly rate charged by the department of justice agency legal services bureau for the provision of legal services to state agencies. The substitute judge must be reimbursed for travel expenses as provided for in 2-18-501 through 2-18-503. When the substitute

judge has accepted jurisdiction, the clerk of the workers' compensation court shall mail a copy of the assumption of jurisdiction to each attorney or party of record. The certificate of service must be attached to the assumption of jurisdiction form in the court file.

(4) The workers' compensation judge shall maintain a list of persons who are interested in serving as a substitute workers' compensation judge in the event of a recusal by the judge and who prior to being put on the list of potential substitutes have been admitted to the practice of law in Montana for at least 5 years, currently reside in Montana, and have resided in the state for 2 years.

39-71-2904. Direct appeal to supreme court. Notwithstanding 2-4-701 through 2-4-704, an appeal from a final decision of the workers' compensation judge shall be filed directly with the supreme court of Montana in the manner provided by law for appeals from the district court in civil cases.

Utah

34A-2-801. Initiating adjudicative proceedings -- Procedure for review of administrative action.

(1) (a) To contest an action of the employee's employer or its insurance carrier concerning a compensable industrial accident or occupational disease alleged by the employee or a dependent any of the following shall file an application for hearing with the Division of Adjudication:

(i) the employee;

(ii) a representative of the employee, the qualifications of whom are defined in rule by the commission; or

(iii) a dependent as described in Section 34A-2-403.

(b) To appeal the imposition of a penalty or other administrative act imposed by the division on the employer or its insurance carrier for failure to comply with this chapter or Chapter 3, Utah Occupational Disease Act, any of the following shall file an application for hearing with the Division of Adjudication:

(i) the employer;

(ii) the insurance carrier; or

(iii) a representative of either the employer or the insurance carrier, the qualifications of whom are defined in rule by the commission.

(c) A person providing goods or services described in Subsections 34A-2-407(11) and 34A-3-108(12) may file an application for hearing in accordance with Section 34A-2-407 or 34A-3-108.

(d) An attorney may file an application for hearing in accordance with Section 34A-1-309.

(2) Unless a party in interest appeals the decision of an administrative law judge in accordance with Subsection (3), the decision of an administrative law judge on an application for hearing filed under Subsection (1) is a final order of the commission 30 days after the day on which the decision is issued.

(3) (a) A party in interest may appeal the decision of an administrative law judge by

filing a motion for review with the Division of Adjudication within 30 days of the date the decision is issued.

(b) Unless a party in interest to the appeal requests under Subsection (3)(c) that the appeal be heard by the Appeals Board, the commissioner shall hear the review.

(c) A party in interest may request that an appeal be heard by the Appeals Board by filing the request with the Division of Adjudication:

(i) as part of the motion for review; or

(ii) if requested by a party in interest who did not file a motion for review, within 20 days of the day on which the motion for review is filed with the Division of Adjudication.

(d) A case appealed to the Appeals Board shall be decided by the majority vote of the Appeals Board.

(4) All records on appeals shall be maintained by the Division of Adjudication. Those records shall include an appeal docket showing the receipt and disposition of the appeals on review.

(5) Upon appeal, the commissioner or Appeals Board shall make its decision in accordance with Section 34A-1-303.

(6) The commissioner or Appeals Board shall promptly notify the parties to a proceeding
before it of its decision, including its findings and conclusions.

(7) The decision of the commissioner or Appeals Board is final unless within 30 days after the date the decision is issued further appeal is initiated under the provisions of this section or Title 63G, Chapter 4, Administrative Procedures Act.

(8) (a) Within 30 days after the day on which the decision of the commissioner or Appeals Board is issued, an aggrieved party may secure judicial review by commencing an action in the court of appeals against the commissioner or Appeals Board for the review of the decision of the commissioner or Appeals Board.

(b) In an action filed under Subsection (8)(a):

(i) any other party to the proceeding before the commissioner or Appeals Board shall be made a party; and

(ii) the commission shall be made a party.

(c) A party claiming to be aggrieved may seek judicial review only if the party exhausts the party's remedies before the commission as provided by this section.

(d) At the request of the court of appeals, the commission shall certify and file with the court all documents and papers and a transcript of all testimony taken in the matter together with the decision of the commissioner or Appeals Board.

Relevant Oklahoma Statutory Provisions

In Oklahoma, judges in the workers' compensation court hear and decide disputed cases. The qualification and appointment provisions are set forth below, as are the provisions for a presiding judge and an administrator. Mediation is also provided by statute, which is set forth below.

Okla. Stat. 85-303. Workers' Compensation Court - Judges. A. There is hereby created the Workers' Compensation Court which shall consist of ten (10) judges, notwithstanding any reduction in the number of judges by operation of law before the effective date of this act. Each judge of the Court shall be appointed to a designated numbered position on the Court. The positions shall be numbered one through ten, no more than seven of which shall be permanently assigned to the Oklahoma City location of the Workers' Compensation Court and no less than three of which shall be permanently assigned to the Tulsa location of the Workers' Compensation Court. The initial terms of the following dates:

Position 1 shall expire 7-1-14.
Position 2 shall expire 7-1-14.
Position 3 shall expire 7-1-14.
Position 4 shall expire 7-1-12.
Position 5 shall expire 7-1-12.
Position 6 shall expire 7-1-16.
Position 7 shall expire 7-1-16.
Position 8 shall expire 7-1-12.
Position 9 shall expire 7-1-12.
Position 10 shall expire 7-1-14.

Provided, judges who are serving unexpired terms on the Workers' Compensation Court on the effective date of this act shall serve on the Court created by this section until their respective terms expire as provided in this act. Thereafter, each position shall be filled by a judge appointed to serve an eight-year term. Judges serving unexpired terms on the effective date of this act shall be eligible upon expiration of such terms for appointment to one term of eight (8) years pursuant to this section. After a judge serves an eight-year term, such judge shall be eligible to reapply for an additional term. When a vacancy on the Court occurs or is certain to occur, or for initial appointments to the Court, the Judicial Nominating Commission shall choose and submit to the Governor and the Chief Justice of the Supreme Court the names of three persons for each appointment, each of whom has previously notified the Commission in writing that he or she will serve as a judge if appointed. The Governor shall appoint one of the nominees to fill the vacancy with the advice and consent of the Senate. If the Governor fails to do so within sixty (60) days, the Chief Justice of the Supreme Court shall appoint one of the nominees with the advice and consent of the Senate, the appointment to be certified to the Secretary of State. Appointments by the Governor to fill a position for a term commencing July 1 shall be made by April 15. If the April 15 deadline cannot be met, the Governor shall notify the President Pro Tempore of the Senate of the date when the appointment is expected to be made. If the Senate fails to confirm within ninety (90) days, the Governor may select from the two remaining nominees or request three additional nominees from the Judicial Nominating Commission.

B. A judge of the Court shall have been licensed to practice law in this state for a period

of not less than five (5) years and shall have not less than five (5) years of workers' compensation experience prior to appointment. Each judge, before entering upon the duties of office, shall take and subscribe to an oath of office and file the same with the Secretary of State. Each judge shall continue to serve until his or her successor has been appointed and qualified. A judge may be removed for cause by the Court on the Judiciary prior to the expiration of his or her term.

C. Each judge shall receive a salary equal to that paid to a district judge of this state, and shall devote full time to his or her duties and shall not engage in the private practice of law during the term in office.

D. The Court shall have the authority to adopt reasonable rules within its respective areas of responsibility including the rules of procedure for the Court en banc, after notice and public hearing, for effecting the purposes of the Workers' Compensation Code. All of the judges of the Court shall be present at all meetings wherein rules are adopted or amended. All rules, upon adoption, shall be submitted to the Supreme Court, which shall either approve or disapprove them within thirty (30) days. All rules, upon approval by the Supreme Court, shall be published and be made available to the public and, if not inconsistent with the law, shall be binding in the administration of the Workers' Compensation Code.

E. The Court is hereby designated and confirmed as a court of record, with respect to any matter within the limits of its jurisdiction, and within such limits the judges thereof shall possess the powers and prerogatives of the judges of the other courts of record of this state, including the power to punish for contempt those persons who disobey a subpoena, or refuse to be sworn or to answer as a witness, when lawfully ordered to do so.

F. The principal office of the Court shall be situated in the City of Oklahoma City in quarters assigned by the Department of Central Services. The Court may hold hearings in any city of this state. The Tulsa location of the Workers' Compensation Court shall not be closed without the approval of the Legislature.

G. All county commissioners and presiding district judges of this state shall make quarters available for the conducting of hearings by a judge of the Court upon request by the Court.

H. The judges of the Court shall determine the qualifications necessary for the position of Administrator. The qualifications shall be submitted to the Chief Justice of the Supreme Court for approval, disapproval or modification.

I. Judges of the Workers' Compensation Court may punish for direct contempt pursuant to Sections 565, 565.1 and 566 of Title 21 of the Oklahoma Statutes.

J. The Court shall be vested with jurisdiction over all claims filed pursuant to the

Workers' Compensation Code. All claims so filed shall be heard by the judge sitting without a jury. The Court shall have full power and authority to determine all questions in relation to payment of claims for compensation under the provisions of the Workers' Compensation Code. The Court, upon application of either party, shall order a hearing. Upon a hearing, either party may present evidence and be represented by counsel. Except as provided in Section 40 of this act, the decision of the Court shall be final as to all questions of fact and law. The decision of the Court shall be issued within sixty (60) days following the submission of the case by the parties. The power and jurisdiction of the Court over each case shall be continuing and it may, from time to time, make such modifications or changes with respect to former findings or orders relating thereto if, in its opinion, it may be justified.

85-304. Presiding judge. A. The Governor shall appoint from among the judges of the Workers' Compensation Court a presiding judge of the Court who shall serve for a two-year term commencing with the initial appointment beginning January 1, 2013. The presiding judge serving on the effective date of this act shall serve the remainder of the term. If a presiding judge resigns the office during the term, the Governor shall appoint a new presiding judge to serve the remainder of the term.

B. The presiding judge shall preside at all meetings of the judges of the Court as may be necessary; perform such other supervisory duties as the needs of the Court may require; preside at all hearings before the Court en banc and at all conferences at which appeals and other matters are considered; make all procedural rulings for the Court except those to be made in the course of hearings before a single judge; assign or direct the assignment of cases to the several judges for hearing at places the presiding judge shall designate; direct and supervise the work of all employees of the Court; handle, oversee and be responsible for all administrative affairs of the Court, including but not limited to those of personnel, budgetary and financial management; and bear such other responsibilities and duties as may be necessary to operate the Court in an efficient manner. For the period during which the presiding judge is disqualified, disabled or absent, the presiding judge may designate another judge to act as presiding judge.

85-305. Administrator of Workers' Compensation Court. A. The chief administrative officer of the Workers' Compensation Court shall be the Administrator of the Workers' Compensation Court, who shall be subject to the general supervision of the presiding judge of the Court, subject to the general administrative authority of the Chief Justice of the Supreme Court.

B. The person serving as Administrator on the effective date of this act shall be appointed by the Governor with the advice and consent of the Senate. The Administrator shall serve at the pleasure of the Governor.

C. The salary of the Administrator shall be ninety percent (90%) of the authorized salary of a judge of the Court.

85-306. Administrator - Powers and duties. A. In addition to other duties, the Administrator of the Workers' Compensation Court, subject to approval of the presiding judge, shall organize, direct and develop the administrative work of the Workers' Compensation Court, including docketing, clerical, technical and financial work, establish hours of operation, and perform such other duties relating to matters within the purview of the Court. The Administrator shall employ other employees of the Court, within budgetary limitation, necessary to carry out the work and orders of the Court in an efficient and expedient manner.

B. The Administrator shall have the following powers and duties:
1. To hear and approve settlements pursuant to direction by the judges of the Court;
2. To review and approve own-risk applications and group self-insurance associations applications;
3. To monitor own-risk, self-insurer and group self- insurance programs in accordance with the rules of the Court;
4. To contract with an appropriate state governmental entity, insurance carrier or approved service organization to process, investigate and pay valid claims against an impaired self-insurer, charges for which shall be paid from the proceeds of security posted with the Administrator as provided in Section 51 of this act;
5. To establish a toll free telephone number in order to provide information and answer questions about the Court;
6. To hear and determine claims concerning disputed medical bills;
7. To promulgate necessary rules subject to the approval of the presiding judge; and
8. Such other duties and responsibilities authorized by law or as the judges of the Court may prescribe.

85-307. Employee testimony - Solicitation and recommendation to attorneys and physicians. A. No employee of the Administrator of the Workers' Compensation Court shall be competent to testify on any matter before a court concerning any information the employee has received through the performance of the employee's duties under the provisions of the Workers' Compensation Code.

B. The Administrator and employees of the Administrator shall not solicit employment for any attorney or physician nor shall they recommend or refer any claimant or employer to an attorney or physician. If the Administrator or any employee of the Administrator makes such a solicitation, recommendation or reference, that person, upon conviction, shall be guilty of a misdemeanor punishable, for each offense, by a fine of not more than One Thousand Dollars ($1,000.00) or by imprisonment not to exceed one (1) year, or by both such fine and imprisonment. The Administrator shall immediately terminate the employment of any employee who is guilty of such solicitation, recommendation or reference. An Administrator or judge of the Workers' Compensation Court guilty of such solicitation, recommendation or reference shall be subject to removal from office.

C. No judge of the Court shall engage in any ex parte communication with any party to an action pending before the Court or with any witness or medical provider regarding the merits of a specific matter pending before the judge for resolution. Any violation of this provision shall subject the judge to disqualification from the action or matter upon presentation of an application for disqualification.

D. An attorney and counselor shall not deduct or withhold any portion of a judgment from a court of law, settlement proceeds of a client, or any monies held in trust for a client for the purpose of donating or contributing funds or monies to a political fund, political action committee, campaign of any kind, or candidate for state, federal or local office.

Relevant Missouri Statutory Provisions

In Missouri, the statute sets forth the summary nature of the proceedings. Relevant provisions are set forth below.

Mo. Stat. 287.550. All proceedings before the commission or any commissioner shall be simple, informal, and summary, and without regard to the technical rules of evidence, and in accordance with section 287.800. All such proceedings shall be according to such rules and regulations as may be adopted by the commission.

287.560. The division, any administrative law judge thereof or the commission, shall have power to issue process, subpoena witnesses, administer oaths, examine books and papers, and require the production thereof, and to cause the deposition of any witness to be taken and the costs thereof paid as other costs under this chapter. Any party shall be entitled to process to compel the attendance of witnesses and the production of books and papers, and at his own cost to take and use depositions in like manner as in civil cases in the circuit court, except that depositions may be recorded by electronic means. The party electing to record a deposition by electronic means shall be responsible for the preparation and proper certification of the transcript and for maintaining a copy of the tape or other medium on which the deposition was recorded for the use of the division or any party upon request. Copies of the transcript shall be provided to all parties at a cost approved by the division. Subpoena shall extend to all parts of the state, and may be served as in civil actions in the circuit court, but the costs of the service shall be as in other civil actions. Each witness shall receive the fees and mileage prescribed by law in civil cases, but the same shall not be allowed as costs to the party in whose behalf the witness was summoned unless the persons before whom the hearing is had shall certify that the testimony of the witness was necessary. All costs under this section shall be approved by the division and paid out of the state treasury from the fund for the support of the Missouri division of workers' compensation; provided, however, that if the division or the commission determines that any proceedings have been brought, prosecuted or defended without reasonable ground, it

may assess the whole cost of the proceedings upon the party who so brought, prosecuted or defended them. The division or the commission may permit a claimant to prosecute a claim as a poor person as provided by law in civil cases.

287.570. If any person subpoenaed to appear at any hearing or proceeding, fails to obey the command of such subpoena without reasonable cause, or if any person at attendance at any hearing or proceeding shall without reasonable cause, refuse to be sworn, or to be examined, or to answer a question, or to produce a book or paper or to subscribe or swear to his deposition, he shall be deemed guilty of a misdemeanor, and on conviction thereof shall be punished by a fine of not more than five hundred dollars, or by imprisonment in the county jail for not more than one year, or by both such fine and imprisonment, and may be prosecuted therefor in any court of competent jurisdiction, and in case of a continuing violation, each day's continuance thereof shall be, and deemed to be, a separate and distinct offense.

Relevant Oklahoma Statutory Provisions - Mediation

In Oklahoma, mediation is provided by statute, which is set forth below.

Okla. Stat. 85-320. Workers' compensation counselor or ombudsman program.
A. The Administrator of the Workers' Compensation Court shall establish a workers' compensation counselor or ombudsman program to assist injured workers, employers and persons claiming death benefits in obtaining benefits under the Workers' Compensation Code.
B. Workers' compensation counselors or ombudsmen shall provide information to injured workers; investigate complaints; communicate with employers, insurance carriers, self-insurers, and health care providers; provide informational seminars and workshops on workers' compensation for medical providers, insurance adjustors, and employee and employer groups; and develop informational materials for employees, employers and medical providers.
C. The Administrator shall mail a notice to the injured worker within ten (10) days of the filing of an Employer's First Notice of Injury. The notice shall advise the injured worker of the availability of the services of the Workers' Compensation Court's counselor or ombudsman program and of the availability of mediation to assist the injured worker. The Administrator shall provide contact information for the Court's counselor or ombudsman program and all such additional information as the Administrator may determine necessary.
D. The Administrator shall develop a program by April 2, 2012, that provides for annual training for own-risk employers and claims representatives handling workers' compensation claims in Oklahoma. The training shall include information about the counselor and ombudsman program, mediation, and other services provided by the Workers' Compensation Court.

85-321. Mediation.

A. Mediation shall be available to any party to a claim arising pursuant to the provisions of the Workers' Compensation Code, subject to limitations pertaining to certified workplace medical plans and except for claims against the Multiple Injury Trust Fund.

B. Unless ordered by the Workers' Compensation Court, mediation shall be voluntary, and shall not be conducted without the consent of both parties. Mediation is not a prerequisite to the commencement of a claim for benefits under the Workers' Compensation Code. A request for mediation or consent to mediate does not invoke the jurisdiction of the Court.

C. The Court may order mediation in any case in which the Court believes that mediation may be beneficial to a prompt and efficient resolution of the claim.

D. A request for mediation may be made by either party and shall be made in writing to the Administrator of the Workers' Compensation Court who shall set the case for prehearing before the assigned judge within fifteen (15) days. At the prehearing, the judge shall appoint a mediator and issue an order reflecting such appointment. The mediator shall contact the parties and schedule a mediation session within thirty (30) days of such order, unless otherwise agreed to by the parties.

E. Mediation is confidential and no part of the proceeding shall be considered a matter of public record. Recommendations of the mediator are not binding unless the parties enter into a settlement agreement. If an agreement is not reached, the results and statements made during the mediation are not admissible in any following proceeding.

F. The Court shall be responsible for certifying those persons who are eligible and qualified to serve as mediators. An individual may be certified as a mediator if the applicant meets the qualifications as required by the Court. A certified mediator may be an attorney or non-attorney who has worked in the area of Oklahoma workers' compensation benefits for at least five (5) years. Mediators serving as Court certified mediators on the effective date of this act shall serve the remainder of their respective five-year certification periods and may reapply for successive certification periods.

G. Each certified mediator shall remain on the list for five (5) years, unless removed. Mediators shall be required to complete at least six (6) hours of continuing education per two-year period in the areas of mediation and workers' compensation. Proof of compliance with this requirement shall be submitted to the Administrator. This continuing education requirement shall be in addition to any other such general requirement which may be required by the Oklahoma State Bar Association. Cost of continuing education is to be borne by the applicant.

H. Mediators shall be compensated at the rate or fee as determined by the mediator; provided, however, the rate or fee shall not exceed a maximum rate to be established by the Administrator or Court by rule. The cost of mediation shall be paid by the respondent or its insurance carrier. A mediator must schedule mediations for a minimum two (2) hour block of time, and may not schedule more than one mediation to take place at a time.

I. At the time of a mediation, the claimant shall be in attendance unless all parties agree, and all parties shall be represented during the entire mediation session by a person with full settlement authority to settle any issue of the claim. If a party does not

have full settlement authority, or does not participate in good faith in the mediation process, the mediator shall report to the assigned judge of the Court who may for good cause shown assess costs, attorney fees, and sanctions.
J. To encourage early resolution of claims, an injured employee may participate in mediation without counsel. Upon compromise settlement of the claim, the parties may submit the settlement agreement to the Administrator for final approval.

APPENDIX V. Report on Streamlining Permanent Disability Compensation

This appendix contains a table from a 2008 study of permanent partial disability by Edward Welch, School of Labor and Industrial Relations, Michigan State University, including a summary table extracting some of the information therefrom. The table provides a breakdown of the PPD attributes as applied across state workers' compensation programs. A state with fewer attributes listed could be viewed as having a PPD process that involves a less complex execution. The study, including explanation of the categories and assumptions in compiling the table, can be found at http://hrlr.msu.edu/hr_executive_education/wcid/#.UDOeNUKWn-L

Some excerpts relating to states that use specific vocational factors to modify impairment rating are included. Other documents on Professor Welch's Workers' Compensation website include an analysis of PPD benefits and a state by state summary of process for arriving at compensation for permanent injuries or wage loss.

Also included in this appendix is an excerpt from Montana's workers' compensation law regarding its permanent partial disability mechanism, which is the closest model to that recommended in this Report.

Vocational Factors Used in Computation of PPD Benefits (from Welch Study)

Vocational factors, commonly education, age, and nature of work are used to compute the level of PPD benefits, in some cases along with impairment ratings. In states with an asterisk, return to work affects the PPD calculation. In some states return to work may include ability to return to work or an offer of work. Of the states below, Montana is the closes to the recommendation made in this report. Montana uses a pure impairment

rating if the claimant returns to work. If the claimant fails to return to work the rating is increased by a formula that uses vocational factors.

Vocational Factors Used in Computation of PPD Benefits		
All PPD Benefits	**Affects Only Some PPD Benefits**	
	Arkansas*	Montana*
Idaho	Colorado	New Mexico*
Illinois	Iowa	Oregon
Kentucky	Kansas	Wisconsin*
South Carolina	Maryland	Wyoming
Tennessee*		

* An asterisk indicates that return to work affects the PPD calculation.

	Comments Received	Schedule Distinction		Pre-Injury Wages		AMA Guides		Voc Factors		RTW		Able to RTW		Offer of RTW		Duration Fixed			
		WP Only	Other	All	Some	All	Some	All	Some	All	Some	All	Some	All	Some	All	Some	Wage Loss	Worker Choice
Alabama			x	x													x		
Alaska						x													
Arizona			x	x		x							x					x	
Arkansas			x	x		x			x		x				x				
California	x			x		x		x							x				
Colorado			x		x	x			x										
Connecticut				x														x	
Delaware		x		x															
Dist. of Col.			x	x		x												x	
Florida	x			x						x									
Georgia		x		x		x													
Hawaii		x																	
Idaho		x		x				x											
Illinois	x	x		x				x										x	x
Indiana		x																	
Iowa		x		x					x										
Kansas	x		x	x		x			x				x						
Kentucky				x		x		x				x				x			
Louisiana	x		x	x		x												x	x
Maine			x	x		x												x	
Maryland		x		x		x			x										
Massachusetts			x		x		x											x	
Michigan			x	x														x	
Minnesota																			
Mississippi			x	x														x	
Missouri	x	x		x															
Montana	x			x		x			x	x									
Nebraska	x	x		x															
Nevada				x		x										x			
New Hampshire			x	x		x												x	
New Jersey		x		x												x			
New Mexico	x		x	x		x			x	x							x		
New York	x		x	x														x	
North Carolina				x														x	x
North Dakota	x		x			x													
Ohio		x			x													x	
Oklahoma		x		x			x												
Oregon					x				x			x							
Pennsylvania			x	x		x												x	
Rhode Island			x	x		x												x	
South Carolina				x				x											
South Dakota		x		x		x													
Tennessee	x	x		x		x		x		x									
Texas				x		x												x	
Utah		x		x															
Vermont				x		x													
Virginia			x	x														x	
Washington	x		x				x												
West Virginia		x		x			x							x					
Wisconsin			x	x					x		x								
Wyoming	x				x	x			x			x							

Excerpts from the Welch Study regarding Permanent Partial Disability

Arkansas

In Arkansas, ratings are based on the AMA Guides. It has a schedule similar to those used in most states. For unscheduled injuries, if the worker has not returned to work and has not received an offer of work at wages equal to or greater than his or her average weekly wage, vocational factors are considered. Otherwise they are not.

California

In California, the process begins with an evaluation under the AMA Guides. This is then adjusted based on an estimate of *diminished future earning capacity*. It is adjusted further based on vocational factors which yields a percentage rating. A table then converts the percentage to a number of weeks.

Idaho

In Idaho, vocational factors are taken into consideration in all cases.

Illinois

In Illinois, workers may choose between wage-loss benefits and benefits based on an impairment rating, which includes consideration of age, skill, occupation, and other factors. In Illinois, workers may choose between wage-loss benefits and benefits based on an impairment rating, which includes consideration of age, skill, occupation, and other factors.

Iowa

In Iowa, the amount of benefits depends upon the pre-injury wage, the severity of the disability, and vocational factors. For unscheduled disabilities, vocational factors are taken into consideration.

Kansas

Kansas requires the use of the AMA Guides and uses a traditional approach for scheduled injuries. Unscheduled injuries begin with the determination of a percent rating. If the individual has not returned to work at 90 percent of the pre-injury earnings, then additional consideration is given to the employee's reduced ability to perform work tasks and earn wages comparable to what they were earning before the injury.

Kentucky

In Kentucky, the process begins with an impairment rating done with the use of the AMA Guides. This is adjusted by a formula that includes vocational ratings. This is applied to 2/3 of the pre-injury average weekly wage to determine a benefit rate. If the worker lacks the physical capacity to return to work, this benefit rate is multiplied by three. If the rating was less than 50 percent, the worker receives these benefits for 425 weeks. If it was equal to or greater than 50 percent, the worker receives these benefits for 520 weeks.

Excerpts from Montana's workers' compensation laws regarding permanent partial disability

Mon. Stat. 39-71-703

Compensation for permanent partial disability. (1) If an injured worker suffers a permanent partial disability and is no longer entitled to temporary total or permanent total disability benefits, the worker is entitled to a permanent partial disability award if that worker:

(a) has an actual wage loss as a result of the injury; and

(b) has a permanent impairment rating as determined by the sixth edition of the American medical association Guides to the Evaluation of Permanent Impairment for the ratable condition. The ratable condition must be a direct result of the compensable injury or occupational disease that:

(i) is not based exclusively on complaints of pain;

(ii) is established by objective medical findings; and

(iii) is more than zero.

(2) When a worker receives a Class 2 or greater class of impairment as converted to the whole person, as determined by the sixth edition of the American medical association Guides to the Evaluation of Permanent Impairment for the ratable condition, and has no actual wage loss as a result of the compensable injury or occupational disease, the worker is eligible to receive payment for an impairment award only.

(3) The permanent partial disability award must be arrived at by multiplying the percentage arrived at through the calculation provided in subsection (5) by 400 weeks.

(4) A permanent partial disability award granted an injured worker may not exceed a permanent partial disability rating of 100%.

(5) The percentage to be used in subsection (4) must be determined by adding all of the following applicable percentages to the whole person impairment rating:

(a) if the claimant is 40 years of age or younger at the time of injury, 0%; if the claimant is over 40 years of age at the time of injury, 1%;

(b) for a worker who has completed less than 12 years of education, 1%; for a worker who has completed 12 years or more of education or who has received a graduate equivalency diploma, 0%;

(c) if a worker has no actual wage loss as a result of the industrial injury, 0%; if a worker has an actual wage loss of $2 or less an hour as a result of the industrial injury, 10%; if a worker has an actual wage loss of more than $2 an hour as a result of the industrial injury, 20%. Wage loss benefits must be based on the difference between the actual wages received at the time of injury and the wages that the worker earns or is qualified to earn after the worker reaches maximum healing.

(d) if a worker, at the time of the injury, was performing heavy labor activity and after the injury the worker can perform only light or sedentary labor activity, 5%; if a worker, at the time of injury, was performing heavy labor activity and after the injury the worker can perform only medium labor activity, 3%; if a worker was performing medium labor activity at the time of the injury and after the injury the worker can perform only light or sedentary labor activity, 2%.

(6) The weekly benefit rate for permanent partial disability is 66 2/3% of the wages received at the time of injury, but the rate may not exceed one-half the state's average weekly wage. The weekly benefit amount established for an injured worker may not be changed by a subsequent adjustment in the state's average weekly wage for future fiscal years.

(7) An undisputed impairment award may be paid biweekly or in a lump sum at the discretion of the worker. Lump sums paid for impairments are not subject to the requirements of 39-71-741, except that lump-sum payments for benefits not accrued may be reduced to present value at the rate established by the department pursuant to 39-71-741(5).

(8) If a worker suffers a subsequent compensable injury or injuries to the same part of the body, the award payable for the subsequent injury may not duplicate any amounts paid for the previous injury or injuries.

(9) If a worker is eligible for a rehabilitation plan, permanent partial disability benefits payable under this section must be calculated based on the wages that the worker earns or would be qualified to earn following the completion of the rehabilitation plan.

(10) As used in this section:

(a) "heavy labor activity" means the ability to lift over 50 pounds occasionally or up to 50 pounds frequently;

(b) "medium labor activity" means the ability to lift up to 50 pounds occasionally or up to 25 pounds frequently;

(c) "light labor activity" means the ability to lift up to 20 pounds occasionally or up to 10 pounds frequently; and

(d) "sedentary labor activity" means the ability to lift up to 10 pounds occasionally or up to 5 pounds frequently.

APPENDIX VI. Ombudsman Program

This appendix sets for relevant statutory examples of Ombudsman programs from Alabama, Arizona, Florida, and Kentucky.

Alabama

Ala. Code 25-5-290

(a) The Department of Industrial Relations shall establish an Ombudsman Program to assist injured or disabled employees, persons claiming death benefits, employers, and other persons in protecting their rights and obtaining information available under the Workers' Compensation Law.
(b) Providing that the employer and the employee agree to participate in the benefit review conference, the ombudsmen shall meet with or otherwise provide information to injured or disabled employees, investigate complaints, and communicate with employers, insurance carriers, and health care providers on behalf of injured or disabled employees.
(c) Ombudsmen shall be Merit System employees and demonstrate familiarity with the Workers' Compensation Law. An ombudsman shall not be an advocate for any person who shall assist a claimant, employer, or other person in any proceeding beyond the benefit review conference, but may, at all times, provide appropriate information regarding this chapter and rules and regulations promulgated thereunder.
(d) Each employer shall notify his or her employees of the ombudsman's service in a manner prescribed by the Director of the Department of Industrial Relations. The notice shall include the posting of a notice in one or more conspicuous places. The director shall also describe clearly the availability of the ombudsman on the first report of accident form required by this article. The ombudsman shall give each employee with a lost-time accident claim written notice of workers' compensation assistance that is available. The notice shall include a toll-free phone number for employees to reach an ombudsman.
(e) Ombudsmen may conduct benefit review conferences. A benefit review conference may be held between the parties involved in a dispute over any claim arising after January 1, 1993. Such benefit review conference shall be held only by agreement of the employer and employee and shall not be deemed mandatory. The director shall institute and maintain an education and training program for ombudsmen. The ombudsmen shall be trained in the principles and procedures of dispute mediation and the director may consult or contract with the federal mediation and conciliation service or other appropriate organizations to accomplish this purpose.
(f) In conducting benefit review conferences, the ombudsman:
(1) Shall mediate disputes between the parties and assist with the claim consistent with this article and the policies of the department.

(2) Shall inform all parties of their rights and responsibilities under this article, especially in cases in which either party is not represented by an attorney or other representative. An employee shall be advised, in writing which shall be notarized, of his or her right to be represented by counsel and of his or her right to have any settlement of his or her claim reviewed by a court of competent jurisdiction at any time within 60 days after the date of the settlement and at the end of 60 days it shall be final and irrevocable.
(3) Shall ensure that all documents and information relating to the employee's wages, medical condition, and any other information pertinent to the resolution of disputed issues are contained in the claim file at the conference, especially in cases in which the employee is not represented by an attorney or other representative.
(4) May reschedule a benefit review conference if he or she determines that available information pertinent to the resolution of disputed issues is not produced at the benefit review conference.
(5) May not take testimony but may direct questions to an employee, an employer, or a representative of an insurance carrier to supplement or clarify information in a claim file.
(6) May not make a formal record.
(7) May issue a statement with regard to an award of attorney fees in accordance with the amount as provided by Section 25-5-90.

Arizona

Ariz. Stat. 23-110 Industrial commission ombudsman
A. The director of the industrial commission shall employ an ombudsman to assist recipients of workers' compensation benefits.
B. The ombudsman shall not provide legal advice but may provide information about the workers' compensation system and rules governing commission proceedings and may assist in clarifying the methods used to determine a person's workers' compensation benefits.

Florida

Fla. Stat. 440.191 Employee Assistance and Ombudsman Office.—
(1)(a) In order to effect the self-executing features of the Workers' Compensation Law, this chapter shall be construed to permit injured employees and employers or the employer's carrier to resolve disagreements without undue expense, costly litigation, or delay in the provisions of benefits. It is the duty of all who participate in the workers' compensation system, including, but not limited to, carriers, service providers, health care providers, attorneys, employers, managed care arrangements, and employees, to attempt to resolve disagreements in good faith and to cooperate with the department's efforts to resolve disagreements between the parties. The department may by rule prescribe definitions that are necessary for the effective administration of this section.

(b) An Employee Assistance and Ombudsman Office is created within the department to inform and assist injured workers, employers, carriers, health care providers, and managed care arrangements in fulfilling their responsibilities under this chapter. The department may by rule specify forms and procedures for administering this section.
(c) The Employee Assistance and Ombudsman Office shall be a resource available to all employees who participate in the workers' compensation system and shall take all steps necessary to educate and disseminate information to employees and employers. Upon receiving a notice of injury or death, the Employee Assistance and Ombudsman Office may initiate contact with the injured employee or employee's representative to discuss rights and responsibilities of the employee under this chapter and the services available through the Employee Assistance and Ombudsman Office.
(2)(a) If at any time the employer or its carrier fails to provide benefits to which the employee believes she or he is entitled, the employee shall contact the office to request assistance in resolving the dispute. The office may review a petition for benefits filed under s. 440.192 and may attempt to facilitate an agreement between the employee and the employer or carrier. The employee, the employer, and the carrier shall cooperate with the office and shall timely provide the office with any documents or other information that it may require in connection with its efforts under this section.
(b) The office may compel parties to attend conferences in person or by telephone in an attempt to resolve disputes quickly and in the most efficient manner possible. Settlement agreements resulting from such conferences must be submitted to the Office of the Judges of Compensation Claims for approval.
(c) The Employee Assistance and Ombudsman Office may assign an ombudsman to assist the employee in resolving the dispute. The ombudsman may, at the employee's request, assist the employee in drafting a petition for benefits and explain the procedures for filing petitions. The Employee Assistance and Ombudsman Office may not represent employees before the judges of compensation claims. An employer or carrier may not pay any attorneys' fees on behalf of the employee for services rendered or costs incurred in connection with this section, unless expressly authorized elsewhere in this chapter.

Kentucky

Ky. Stat. 342.329 Division of Ombudsman and Workers' Compensation Specialist Services -- Functions -- Ombudsman program -- Toll-free telephone access.
(1) The Division of Ombudsman and Workers' Compensation Specialist Services shall be headed by a director appointed by the commissioner with the approval of the Governor, in accordance with KRS 12.050 and 342.230. The functions of the division shall include:
(a) Serving as an information source for employees, employers, medical, vocational, and rehabilitation personnel, carriers, and self-insurers;
(b) Responding to inquiries and complaints relative to the workers' compensation program;
(c) Advising all parties of their rights and obligations under this chapter;

(d) Assisting workers in obtaining medical reports, job descriptions, and other materials pertinent to a claim for benefits and preparing all documents necessary for a claim application; and
(e) Performing other duties as required by the commissioner through administrative regulations promulgated by the commissioner.
(2) The employee, employer, carrier, self-insured administrator, and medical provider shall promptly comply with reasonable information requests from an ombudsman.
(3) The ombudsman program shall be staffed with personnel trained in techniques performed by ombudsmen and who are familiar with medical and vocational rehabilitation principles and knowledgeable about the provisions of this chapter and applicable administrative regulations.
(4) A toll-free telephone number shall be provided throughout the Commonwealth to insure easy access by all parties to the division.